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Editor's Page

"SCIENTIFIC KNOWLEDGE," ACCORDING TO Joseph Eaton in our opening article in this issue, "is neither exclusive nor secret. . . . The artistic or clinical elements . . . are more personal." This does not mean that the personal is always the secret or will forever be so. It does highlight that knowledge is not precisely the same as understanding and that attention must continue to be directed internally as well as externally.

Until disciplined and scientific study is fully directed to the problems of human relationship, we shall not go very far. The encouraging fact that the social has reasserted itself in our profession, not merely as component but as central to the distinctive process, probably makes the social sciences easier to assimilate, but not too easy unless and until our total field, like the services in the Pentagon, can be integrated.

At the moment, we must confess to uneasiness at the currently wide gap between class and field. Sometimes the school is ahead of the field (it should normally be ahead in teaching principles and concepts); sometimes it falls behind certain experimental outposts. We remind ourselves, however, that communication and collaboration between the scientist and teacher will avail us little if the feedback to and from practice thins and blocks.

There have always been attacks on practice, chiefly by those who have never seriously engaged in it. Pure scientists may be snobbish about practice, and fund-raisers maintain it costs too much, but to all this, vestigial rivalries in the field add their several confusions. (One still reads papers, for instance, that when a worker in a family agency uses a bit of group process this is an adapted kind of casework, or if a worker in a community center uses interviewing process, this is "group work" with a casework fringe on top! Do they not know that they are social workers capable of offering several methods basic to social work?)

We like Eaton's social worker who "hunched" enough to do a manicure, but what school today would or could do other

than teach the use of relationship with different clinical types including the "withdrawn and hostile" client? Whether knowledge about the management of the relationship is scientifically valid or not, it has gone far beyond the intuitional stage, and qualified practitioners everywhere should have it at their fingertips. The social worker operating in this most difficult of all fields—human relations—must not only know, but to some extent, heal himself. Yet how little do we practice among ourselves what we know about attitudes, behavior, motivation!

Still further complicating the enormous contribution of science today, one reminds oneself that the cutting edge of science, namely its technology, in an ever expanding mechanistic world, must be balanced by a *technology of the humanities* or men of science will perish along with poets and artists in that day of wrath when the sky is vanished like a scroll and every mountain and island is removed from its place.

How then shall we be saved if the Bell has not yet tolled? Some of the older problems no longer like Apollyon straddle the whole length of the way—already there is enough knowledge to reduce further and possibly banish them altogether like the Black Plague. Yet there is still underproduction of needed and clearly demanded services. Former mental patients, discharged from hospitals partly because of the discoveries of scientific medicine, find no suitable place to live, no social worker to help guide them back into the normal pathways of living. If there is nothing so unscrupulous as an ideal undisciplined by science, (to borrow from our favorite modern philosopher), let us remember also that there is nothing so dangerous as a scientific discovery unrelated to the welfare of mankind.

Welfare programs are now part of the texture of modern society, here to stay in one form or another, and in these programs, human relationships remain the final challenge. The only objective for the combined insights of science and the humanities is the understanding which will enable us to live decently as human beings. G. H.

Social Work

BY JOSEPH W. EATON

Science, "Art," and Uncertainty in Social Work

SOCIAL WORK PRACTITIONERS apply knowledge, but they vary greatly in their expectations about the degree to which the theoretical bases of their actions can be generalized, tested, and transmitted to others. The slogan "Social work is an art and a science" is commonly used to express the fact that practitioners use ideas of varying degree of knowability. When there is an emphasis on "art," it implies a conviction that decisions are made on the basis of an intuitive and inspirational rationale. They are derived from personal discoveries or from the ideas avowed by model practitioners, the "great" teachers, the unusual clinicians, the gifted consultants. An air of awe and mysticism surrounds such "practice wisdom" and it is psychologically tempting to become enamored of these art (or clinical) aspects of practice.

However, scientific knowledge is neither exclusive nor secret. It can be generalized and thus learned by a good many people. They need only to be able to read and pos-

sess the prerequisite knowledge to apply a new discovery. The artistic or clinical elements, on the other hand, are more personal and appear to require "special" and "unique" attributes. Those who have such skill possess a monopoly that gives them a great deal of status among clients and fellow practitioners. The art emphasis in practice reflects a latent stress on the importance of the individual, and also enhances the importance of the teacher or consultant who is believed to be able to generate such practice wisdom. The co-existence within one system of practice of two frames of thought—of science and of mysticism—serves to make less urgent efforts to analyze "artistic" ideas scientifically.¹ Under examination, though, such ideas lose much of the clinical halo.

Knowability is never absolute. Areas of ignorance and error always exist no matter how much research and experience are applied to the solution of a human problem. In certain respects every man is (1) like all other men, (2) like some other men, (3) like

JOSEPH W. EATON, Ph.D., is lecturer at the School of Social Welfare, University of California, Los Angeles.

¹ Practice also involves considerations of policy and social values. This article will not deal with them.

no other man.² (1) and (2) make it possible to apply science to practice; (3) represents the limiting condition. Social workers know that "every case is different," but this fact does not preclude the application of experiences derived from similar cases. Knowledge, while no key to certainty, contributes to a more modest goal, namely, to increase the frequency of socially appropriate decisions at the expense of the number of inappropriate or erroneous ones.

For example, the balance of knowledge and uncertainty can be well illustrated in examining what is known about birth trends. The number of babies born in any year can be predicted fairly well on the basis of past trends for a large population until major changes in technology, socioeconomic conditions, and people's values take place, as happened after World War II.³ It is possible to construct an experience table for any group for having a live birth at a given age.⁴ Families of the Catholic faith are much more likely to have a baby during their first year of marriage than Jewish or Protestant families. The latter more often practice birth control. Social scientists have interviewed couples and

learned much about how their behavior as parents is affected by their conscious and subconscious attitudes toward having a family.⁵ Obstetricians know that Caesarean deliveries are indicated with mothers of certain body builds. Knowledge can guide action with regard to those aspects of pregnancy that can be generalized to specific categories of women. But this still leaves out from coverage elements in every individual case that vary within categories of cases. It is here that clinical and artistic skills become relevant.

To illustrate further: scientific knowledge can facilitate a reduction in the incidence of maternal and infant mortality nearly to the point of the biologically minimum frequency. This knowledge is applied by insurance companies in calculating rates for maternity health policies. Builders have used knowledge about family growth cycles to design two-bedroom houses, "with an attic that can be made into a room." Social workers, too, have been able to generalize, for instance, that unmarried mothers uninterested in children are likely to experience deep personal conflict about having their baby. The educated social practitioner does not have to gamble on the basis of guesswork and chance. He can play against fate with loaded dice.

But the gaps in any man's knowledge are still great. Couples who avow that they do not want children have "accidents." Some become excellent parents. A healthy, well-protected baby might fall and have a traumatic brain injury. Scientific knowledge cannot anticipate and control all of the factors which make the future. It cannot prevent inappropriate and erroneous recommendations—but it can reduce their frequency.

The helping professions are under much pressure, both from within and without, to demonstrate that their practices are the

² Clyde Kluckhohn and Henry A. Murray, *Personality in Nature, Society and Culture* (New York: Alfred A. Knopf, 1955), p. 53.

³ In 1933 Warren Thompson and T. K. Whelpton made a remarkable forecast of the country's future population growth. In 1940, the Bureau of Census found that the actual count of the population of the United States, before being corrected for the bureau's own underenumeration, was less accurate than the estimates these two demographers had made almost two decades before! William Petersen notes that today demographers look back with nostalgia to this incident. "For, ever since the end of the war, the American birth rate has undergone a metamorphosis which has left them only slightly less bewildered than the rest of the nation. Whereas it once was expected that the population would stabilize itself about the 175,000,000 mark, it seems now that by 1975 there will be 220,000,000 Americans." See "The New American Family: Causes and Consequences of the Baby Boom," *Commentary*, Vol. 21, No. 1 (January 1956).

⁴ Joseph W. Eaton and Albert J. Mayer, *Man's Capacity to Reproduce* (Glencoe, Ill.: The Free Press, 1954), p. 26.

⁵ See, for example, *Current Research in Human Fertility*, Papers presented at the 1954 Annual Conference of the Milbank Memorial Fund (New York: Milbank Memorial Fund, 1955), 164 pp.

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most plausible and most promising of known techniques. Legislators and boards of trustees of voluntary agencies want their funds to be expended in the best possible manner. Practitioners are interested in maximizing their self-confidence in their knowledge and skill. Persons who seek help also need reassurance from evidence about the validity of knowledge used in the process.

In spite of these social forces for more precise knowledge, evaluative research about social practices is still in its infancy. Malpractice is virtually undefinable in social work. While it does occur, it is hard to prove. As David French has pointed out, there is a great lack of real knowledge regarding the profession's effectiveness.⁶ One need not ignore a clinically promising idea just because it has not yet been tested, but how long can we go on using it as if it were proved? Social workers are therefore interested in methods to distinguish between plausible ideas that are impossible and those that are probably true.

THE ARTISTIC APPROACH

"I manicured her nails." This is what a social worker did during the first interview with a severely withdrawn and hostile adolescent girl. At the end of the period, the girl began to unburden herself. The manicure, it was discovered later, was interpreted by the adolescent as a symbol of genuine personal interest. Questioned by colleagues who wanted to know how she had established a treatment relationship when others had failed, the worker was hard put to explain her unusual decision. "Somehow I felt I could not talk to the girl as she entered the room, sullen, as if she felt that she was being forced to do something against her will. I saw her nails. They looked as unhappy as she did."

"It gave us a chance to get acquainted,"

⁶ David G. French, *An Approach to Measuring Results in Social Work* (New York: Columbia University Press, 1952), p. 12.

she added as an afterthought, "without having to talk."

Hunches like this make the difference between relative success and relative failure in social practice. Much of social welfare work looks operationally more like cooking than surveying, in the degree to which generalized knowledge is utilized. In surveying, there are geometrical theorems which can be used to calculate precise measurements and to make very accurate predictions of distances and angles. Cooking (of the *precookbook* variety) is much more empirical. There was more reliance on experience alone without theory. "Grandmother's recipe" is something apparently unique. She had no written recipe; she just "knew" how much of each ingredient was needed.

The artistic theory urges reliance on the best people in the field who are spoken of as having "a good clinical sense," "amazing intuition," or "they somehow just can smell a diagnosis." Like any secret process, the clinical hunch can work wonders in the hand of the inventor, but unfortunately, it will go to the grave with him. How many of these attributed skills are a function of the organizational power and reputation? When the nature and the limits of genius remain unexplored, it cannot become part of the body of social knowledge. Mary E. Richmond found social casework to be an art which each practitioner must find through "personal revelation," but she started this field on its way toward the application of knowledge by writing *Social Diagnosis*.⁷

THE SCIENTIFIC APPROACH

The artistic approach to practice—and every practitioner has such supreme moments of insight—is important because many new discoveries are made that way, but unless these personal inventions are translated into ideas that can be shared, they are useless to others. They must be

⁷ New York: Russell Sage Foundation, 1917, p. 103.

described and generalized to be communicated to novices and less-endowed practitioners. Furthermore, it is dangerous to rely too much on such unverified artistic "wisdom"—the chances of error in individual judgment are considerable.

Artistic or clinical skill is a mental process of combining conscious and unconscious variables or factors appropriate to a problem. It is logically similar to what goes on in a Univac machine. A great number of facts, believed to be relevant, can be fed into the machine, with numerical weights attached to each factor in accordance with its relative importance. Univac then is able to solve an incredibly complex regression equation to arrive at a value for x hitherto unknown.

The human brain is less reliable mechanically than Univac, but it is capable of relating factors to each other with more freedom and originality. It has a creativity which is beyond our present capacity to understand, and may never be encompassed in its entirety by scientific knowledge. However, when scientific procedures are applied to intuition or hunches, they will turn out to be less mysterious than they appear.

While many philosophers doubt that science can ever discover the real essence of anything and absolute validity will always elude us, we can approximate it. It is logically unwarranted to accept anything with absolute finality, even if in practice people often must act as if this were the case. Testing and retesting are the key to scientific progress. As an example, let us briefly review the emergence of the concept of penis envy.

From Hunch to Hypothesis

Observation: Sigmund Freud observed that some girls seemed to be envious of boys because of their possession of a penis.

Conceptualization: Freud viewed this behavior to be more significant than other expressions of envy which children make about everything they do not have and wish

to have. He conceptualized it as *penis envy*, a biologically determined emotion in all women.

Generalization: Freud inferred that *penis envy* is the basis of the universal desire of girls to be boys, to which women must learn to make an adjustment. The absence of the penis in women often produces in the male a lasting depreciation for females.⁸

Retesting of Hypothesis

Observation: Karen Horney confirmed that some of her girl patients expressed envy of boys because of their penis.

Generalization: "There is no reason, however, to think that this wish is any more significant than their equally frequent wish to have a breast."⁹

An alternate generalization was proposed: "Penis envy" reflects more social than sexual envy of the advantageous male social position in our culture. The wish of some women to be men is conceptualized as a cultural rather than sexual desire.

Suggestion for Future Inquiries

Horney concludes that generalizations about penis envy are needed for specific categories of persons:

I suppose everyone agrees with Freud that differences in sexual constitution and function influence mental life. But it seems unconstructive to speculate on the exact nature of this influence. The American woman is different from the the German woman; both are different from certain Pueblo women. The New York society woman is different from the farmer's wife in Idaho. The way specific

⁸ Sigmund Freud, *The Basic Writings of Sigmund Freud*, translated and edited, with an introduction by A. A. Brill (New York: Modern Library, 1938), p. 595. For a more detailed application of this general theory to feminine psychology, see Helene Deutsch, *The Psychology of Women* (New York: Grune and Stratton, 1944). Dr. Deutsch was trained in psychoanalysis by Freud and worked with him for many years.

⁹ Karen Horney, *New Ways in Psychoanalysis* (New York: W. W. Norton and Co., 1939), pp. 105-108.

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cultural conditions engender qualities and faculties, in women as in men—this is what we may hope to understand.¹⁰

TRUTH, VALIDITY, AND PROBABILITY

The application of science to social practice problems requires an understanding of three closely related concepts: truth, validity, and probability. They differ logically, but are often used operationally as if they were identical.

Truth is a quality believed to be inherent in nature and the universe. Many philosophers believe that we live in a world of phenomena that are not accidental but determined etiologically. We do not always know what nature's laws are, but with enough wisdom, it is believed, we may discover them or at least approximate them. Absolute truths are affirmed in theology and in the realm of cultural phenomena but the concept is not appropriate for the sciences. No matter how regularized events are, nature can never be considered to follow a law with absolute certainty. No one could accumulate enough evidence to prove its existence.

Acceptance or rejection of a hypothesis in science is based on a concept of approximate certainty—*validity*. It is the *approximation of a state of being correct by some designated criterion*. It may be valid that membership in an adolescent settlement house club deters youngsters from belonging to a delinquent gang. This hypothesis is more valid when the criterion of delinquency is "Arrest by the police." It is much less valid if the criterion is "Any socially disapproved behavior," including the consumption of alcoholic beverages by minors and transgression against the sex mores. Thus, a generalization can be valid without being applicable to every case. The occasional arrest of a settlement house club member for delinquency does not destroy the proposition's validity—it merely serves to reduce its degree of validity.

¹⁰ *Ibid.*, p. 119.

The quality of "degreeness" is expressed in terms of the logical concept of probability. In its everyday use it denotes a conviction about what reality is likely to be. This likelihood is inferred from evidence of what is known, plus knowledge of factors not yet determined. The Los Angeles weather bureau no longer forecasts "rain." Such a conventional categorical statement of what the weather will be has been modified to reflect a probability of rain, to share with the public the meteorologist's estimate that his prediction might fail to come true.¹¹

Philosophers vary somewhat in their definition of the term "probability." Perhaps it can best be described by integral calculus. The concept's meanings can also be expressed quite well nonmathematically, as Cohen and Nagel did:¹²

Probability As Applied to a Conviction

The concept may be used to describe a belief that a given event will take place. If our conviction is absolute, the probability that the event will occur is conventionally described as 1.00; if we are certain that it will not take place, the probability is 0.00. Between these two extreme possibilities of certainty and noncertainty of occurrence lies the probability of all known events: a degree of being more or less certain, but never absolutely certain or uncertain.

Probability As Applied to an Observation

The concept may be used to describe the relative frequency with which an event has been found to occur in nature. It is the ratio of alternate ways it did happen under specified circumstances to the number of ways in which it failed to happen. It can be visually represented as an area under a relative frequency curve.

¹¹ J. C. Thompson, "A Numerical Method for Forecasting Rainfall in the Los Angeles Area," *Monthly Weather Review*, Vol. 78, No. 7 (July 1950), pp. 113-124.

¹² Morris R. Cohen and Ernest Nagel, *An Introduction to Logic and Scientific Method* (New York: Harcourt, Brace and Co., 1934), pp. 164-172.

Probability As Applied to a Hypothesis

The concept may be used to describe an inference derived from conviction and/or observation in terms of the relative frequency with which the inference yields correct conclusions. Correctness must be defined in terms of a specific criterion.

The generalization "Mothers want to keep their babies" is valid, even though there are exceptions. The number of mothers who keep their babies is very large in comparison to the few who do not in every culture. But there are some notable exceptions. Unmarried mothers in America of middle-class status rarely wish to keep their illegitimate offspring.¹³ Nevertheless, the generalization about mothers' wanting to keep their babies is an excellent guide to predicting the behavior of many categories of future mothers. Obstetricians and hospital administrators apply it since they cannot get to know all patients personally. The generalization stands up in enough cases to make it unnecessary for hospital nurses to ask each mother routinely if she wants to keep her baby or wishes to place it for adoption. It is valid if used with knowledge of its probable exceptions.

VALIDITY + ERROR = 100%

The possible applications of a generalization appropriate to a situation can be summarized in the following formula: *The sum total of all events where the generalization is valid, plus those where it is not valid equal 100 percent of all situations to which it might possibly be applied.* Error and validity are two sides of a coin.

A highly probable generalization is rarely applied erroneously. With a less probable generalization, the chances for error are correspondingly greater. The frequency of error is predictable. Error does not invalidate knowledge; it is just the *limiting* condition of its application.

¹³ Henry J. Meyer, Wyatt Jones and Edgar F. Borgatta, "The Decision by Unmarried Mothers to Keep or Surrender Their Babies," *Social Work*, Vol. 1, No. 2 (April 1956), pp. 103-109.

The relationship of error and validity can be illustrated in the field of mental disorders. As Albert Deutsch points out, magic preceded medicine in the treatment of these disorders.¹⁴ The Bible relates what may have been manic-depressive symptoms in King Saul as having been cured by David's harp-playing (I Samuel, xvi). In spite of the many limitations of this procedure, such "treatment" was more humane than the practices of the Middle Ages and the Renaissance, when some mentally ill persons, defined as "witches," were tortured and killed. In Europe during the eighteenth century, most well-to-do and harmless psychotic patients were left alone; others were incarcerated in lunacy asylums. There, chained and treated like wild animals, death was a highly probable form of "discharge." In contemporary practice, the most common form of treatment is custodial care. Patients get decent food and protection against doing violence to themselves and others. They receive at best only symbolic psychological care, but are given fair medical services for physical ailments. In better hospitals they also benefit from "TLC," or Tender Loving Care, by well-motivated lay persons in physically attractive surroundings, and from various forms of medically supervised shock therapy, drug therapy, lobotomy, and psychotherapy.

Knowledge about the validity of these alternate, but not necessarily exclusive techniques, does not lend itself to neat summarization.¹⁵ It can be hypothesized that they might be scaled crudely in terms of the degree of probability to which they add to a patient's potentiality for improvements from particular symptoms of mental stress.

Validity of a treatment procedure is always expressed in the form of a probability

¹⁴ Albert Deutsch, *The Mentally Ill in America* (New York: Garden City, Doubleday, Doran and Co., 1937).

¹⁵ Leo Alexander, *Treatment of Mental Disorders* (Philadelphia and London: W. B. Saunders Co., 1953), pp. 192-280, Chapter XII "Mode of Actions and Results of Psychotherapy and of Physical Treatment of Mental Disorders."

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that a given outcome will occur. Even with the fullest application of what is known, some patients, perhaps as many as 10-20 percent, are still incurable. One day, new and more effective methods of treatment may be discovered that will bring the probability of curing depressed patients close to 1.00, as is true of the treatment for smallpox and illiteracy. Practices valid now will then be displaced by others that are more valid.

VALIDITY AND SECURITY

The elusiveness of certainty is a condition inherent in the nature of the universe. John Dewey and many others have documented this idea by applying the Heisenberg principle of indeterminacy in physics to the social impact of the observer on what he studies. Heisenberg indicated that the making of minute measurements of small particles moving at great speed would be distorted by the device used to measure it. The same effect can be observed in attitude studies, as Nelson N. Foote and Leonard S. Cottrell, Jr., indicate:

Voters when canvassed about their political opinion often find those opinions altered by having attention directed to them. . . . The mere asking of questions, as Socrates found long ago, can have reorganizing and occasionally distressing consequences. Indeed, the mere listening may have profound effects upon the person listened to, as psychotherapists have learned recently.¹⁶

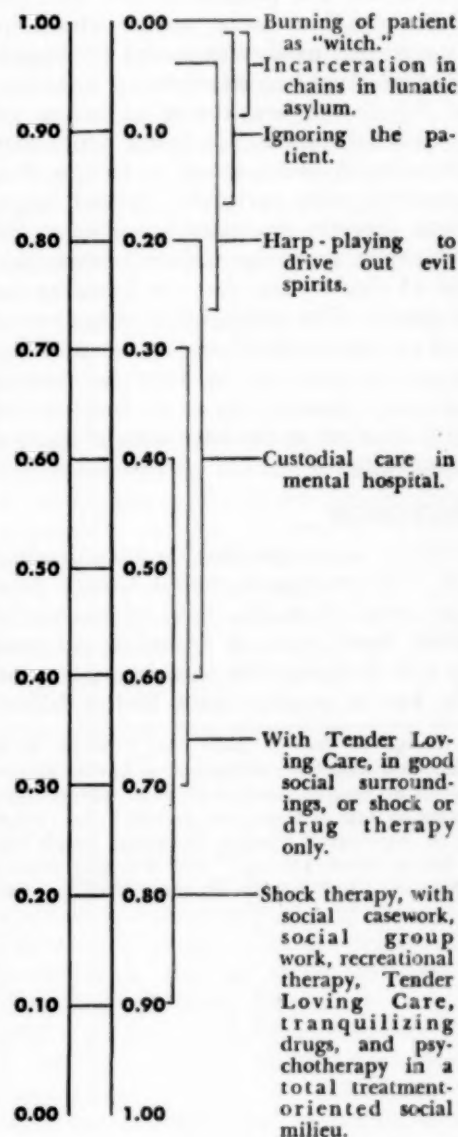
Research about social practice can only be done on the basis of an approximately uniform program. People change somewhat in what they do when there is a study of their acts.

For the practitioner the absolute concept of truth is more comfortable than the rela-

¹⁶ Nelson N. Foote and Leonard S. Cottrell, Jr., *Identity and Interpersonal Competency: A New Direction in Family Research* (Chicago: The University of Chicago Press, 1955), p. 214. For an earlier formulation see John Dewey, *The Quest for Certainty* (New York: Minton, Balch and Co., 1929), pp. 201-204.

Probability of Curing Psychotic Patients by Certain Treatment Methods

ERROR VALIDITY CRITERION OF CURE:
(Survival of Patient As a Useful Person)



tive concept of validity. The practitioner must have confidence in what he knows in order to apply it. Such confidence is hard to come by when there is full awareness that there is also a degree of uncertainty in everything we know. A doctor who injects insulin to treat a disturbed mental patient with shock therapy does not like to think of the one percent chance that this will be fatal.¹⁷ A social worker who helps an unmarried mother to accept permanent separation from her infant wants to believe that this is the best course of action for everyone concerned. He is less ready than most research social scientists to speculate on whether this particular mother might become severely depressed, or whether the child might grow up with a pathological sense of deprivation for not knowing his real mother. The inevitability of some error raises no special problem for the professor writing a textbook or the researcher making an inquiry. Neither has to act in situations which are vital to the happiness of another human being!

CONCLUSION

No case is so unique that its analysis, diagnosis, and treatment cannot benefit from being planned in the light of knowledge derived from cases of a similar category. Few will disagree with this theory in principle, but in practice many find it difficult

to accept. It requires that there be less emphasis on feeling and more on thinking, less on hunching and more on disciplined study.¹⁸ The scientist may seem less "original" than the clinical genius, for the former makes conscious use of knowledge derived from the experience of others, but he is also the only one who can with a degree of confidence add, through his experience, to the total body of accumulated knowledge.

The application of scientific methods to practice is anxiety-provoking. Many practitioners need to believe in their operational assumptions with a fervor resembling that of a faith. However, science is not a faith. It can develop only in men, in institutions, and in professional subcultures which can tolerate some degree of uncertainty and error. It thrives when practitioners can derive adequate satisfaction from the limited power that valid knowledge can give—the power of playing against fate with loaded dice.

Social practitioners confronted daily with heart-rending and complex problems crying for assistance are understandably anxious about maximizing their degree of control through knowledge. But what if this task, to which they are dedicated, is never done so well as to leave life without a challenge? They can help many people, even with their moderately valid knowledge. They cannot help all, but probably few are harmed in the helping process. The occasional exception to this is a necessary risk of scientifically oriented practice. It is a reminder that men are not gods, no matter how hard some may try.

¹⁷ George G. Merrill notes that "insulin shock therapy has long been recognized as having various unfortunate complications, with most surveys citing a mortality rate of about one percent." See "Death Due to Injection of Pyrogen-containing Fluids during Insulin Shock Therapy," *The American Journal of Psychiatry*, Vol. 110, No. 11, (May 1954), pp. 850-852.

¹⁸ Maurice J. Karpf, *The Scientific Basis of Social Work* (New York: Columbia University Press, 1931).

BY SYDNEY KORET

The Social Worker in Private Practice

IN GENERAL, PRIVATE practice signifies the application of one's skills and training under one's own direction. It is not public in nature or in control. It may be legally controlled only in the broadest aspects, such as in the issuing of licenses and in specifying the training and conditions for practice as well as the limitations of practice. But within the limits of such established regulations, if they are adopted, the practitioner is self-disciplined. This means, of course, that the practice is not publicly financed and a fee must be charged. When practice is coupled with social work, it means privately offering social work services, essentially casework services, for a fee.

It is not possible to pose such a definition without considering the inference, the implications, and the ramifications for the social worker and for social work. This is a profession that is steeped in a tradition of public service, publicly financed and agency operated and controlled, and ultimately answerable to the public through the use of boards of directors. This is true whether the agency is a so-called private one financed and supported by public subscription such as the United Fund, the March of Dimes, and the like; or more directly, as in the case of public agencies, governmentally administered and supported through local and federal taxation. Thus, in one sense, the transition to private practice for the social

worker is a complete departure from his past, and offering casework services outside the sponsorship of an agency and conditional upon the payment of a fee may seem at first alien to the entire heritage and concept of social work. But a broader view may conceive of private practice as a natural evolutionary phase in the development of social work.

This seeming paradox is not unique or unknown to the other professions. The difference lies only in the stage of development. Initially, each practice arose from a social and human need and was sponsored and supported by the society which recognized its need and to whom the practitioner ministered. Indeed, the seeming dichotomy never has been resolved. The most primitive tribes supported their witch doctors who were elevated to positions of reverence and respect while they cared for all who required their services. In the fifth century B.C. the work of Hippocrates divided physicians into two categories, amateur and professional. The professional was differentiated by his willingness to take the Hippocratic oath, and to say, in effect, that he would assume responsibility for his actions, exercise as high a degree of competence as he was capable of, and abide by an ethical code which placed the welfare of the patient first. But for many centuries, the physician was most frequently associated with a particular school or religious order. It was only after the Middle Ages, when a considerable amount of knowledge had been accumulated and transmitted, that physicians felt equipped and capable of engaging in private practice on a large scale.

SYDNEY KORET, Ph.D., is director of the Residential Treatment Center of the Convalescent Hospital for Children, Rochester, New York. This paper was presented at the Rhode Island Conference of Social Work in 1957.

And certainly this never assumed its present proportions or its present form until the last three centuries.

But what has happened to the medical profession? It has never been able to separate itself from the roots from which it sprang. It was socially cultivated, socially nurtured, and bears its fruits in a social milieu. It can continue to exist and flourish only as it perseveres in feeding and serving the society to which it owes its prosperity. With all its shortcomings, it never sheds its traditions or its obligations. So we see that at the very moment of its greatest expansion, clinics not only continue to exist, but they increase in quantity and in quality. The individual physician must forever meet his obligations to society by contributing a portion of his time and services, without remuneration, to hospitals and clinics. Thus, the man of medicine never breaks completely with the earliest traditions. The legal agencies of society specify who may practice and what training is required by the issuance of licenses, while at the same time offering the finest opportunities with the construction of new and modern hospitals. When the medical profession violates its heritage or forgets its obligations, attention is focused on socialized medicine.

FINANCING AND FUNCTION

The movement of the medical profession into private practice while continuing to maintain its social obligations has a strong analogy for social work. Somehow there seems to be some feeling that there is something foreign about social workers engaging in private practice. In actuality, social work as a field has been engaged in this to a degree for many years. Social work found its earliest origins in tribal and clan feelings of responsibility for its members. In our more highly organized urban societies this was translated into acts of charity, and bolstered by the doctrines of Christianity. The Elizabethan Poor Laws for the first time transferred the conscience of society into the legal

obligations of society. While the concern of social work was the care of the needy, the aged, the child, and the infirm, it was still met primarily by private philanthropy. The great campaigns for social action that characterized the nineteenth and early twentieth centuries added another aspect to social work. The activity of Pinel and Tewk and Dorothea Lynde Dix brought other phases of human suffering, other than economic, into sharp focus. When the first private agency was opened and the first worker hired "to do good" in the nineteenth century, social work made its great break with the past, and private practice became inevitable. During World War I the need for large numbers of trained persons to help others with the problems of living became apparent. When Smith College offered to train social workers, the first attempt was made to delineate a separate line of work for which there might be a distinct body of knowledge that could be taught and exercised in practice. There was the tacit assumption that someone would be willing to pay for this service. The great depression of the thirties made it crystal clear that private philanthropy could no longer meet the economic needs of people in trouble, and the federal government followed the state and local administrations into the area of public assistance on a mammoth scale. At the present time one cannot conceive of an adequate social welfare program without a tremendous expenditure of federal funds. This, of course, has been officially recognized by elevating the administration of such programs to cabinet rank. But what did all this do to the so-called private agency—that is, the social agency which operates independently of tax money and governmental administration?

With the money-giving and relief function largely removed from its hands, it was essential for the private agency to re-evaluate its functions and to assess its *raison d'être*. Thus the definition of function, the delineating and establishing of services, and

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the understanding of professional status and professional distinctions became of primary concern (Mrs. Sanders and *Harper's* notwithstanding!). For the private agency the essential service evolved has been the casework process, and the excellence or mediocrity of any agency is directly related to its execution of that process through its individual workers. In this light, the progress, the understanding of function, and the refinement and development of methods and techniques in such a comparatively short period of time, less than twenty-five years, are nothing short of phenomenal. Because of this rapid change, however, together with the necessity to alter the focal point in education and borrow from many related disciplines, there has been a heavy reliance upon direct and continuous supervision, and an understandable hesitancy to operate without such support and direction.

A natural consequence of the new direction in social work in private agencies was the consideration of a fee schedule now utilized by many agencies. This was the next major departure from social work tradition. For the first time social workers began to sell their services to the public rather than serving in a purely philanthropic role. True, the faith with the past has been kept by utilizing sliding scales and adjusting rates to ability to pay. Nevertheless, the whole trend in the social work field is for the more advanced agencies to adopt fee-charging. This developed most rapidly in child guidance clinics where the agency was most sharply exposed to the practices of other professions, such as medicine. Within the last four years, one casework agency was established with the policy of a fixed fee. It made no pretensions other than to appeal to the middle- and upper-income groups. It has quadrupled in volume and is self-supporting. Meanwhile, private practice is not at all uncommon in larger communities, such as New York, Boston, Philadelphia, Detroit, and Los Angeles. It is gradually making inroads in

the smaller cities and we must be prepared to recognize this as a fact of life and perhaps avail ourselves of the service.

COMING OF AGE

What is it that makes private practice possible and allows it to evolve and emerge from the agency setting? First of all, a profession must come of age. A body of knowledge must be established which sets itself aside from other disciplines. This must be capable of being taught and then practiced. Adequate schools and supervision are necessary to provide such training. Techniques and methods are developed that are essential but are also susceptible to constant improvement. Second, the role or function of the profession must be clearly understood by its own members. They should be able to conceive of their position and the service they have to offer. In other words, they must have a clear idea of what they are doing. Third, the field must outgrow the status of an ancillary service. It must realize it has more to offer than merely carrying out the dictates or prescriptions of another discipline. It should be able to operate with some degree of independence and security. Fourth, there must be a recognition that there is something to sell which should be paid for. This requires a feeling of self-worth both by the agencies and the individual workers. Fifth, the field must take responsibility for its own actions. This means being able to state its position and being willing to act to support its concepts. It also implies setting up professional organizations and being willing to establish standards and ethical principles and to police itself. Sixth, workers must appear who are able to function without regular supervision and are willing to make decisions and social diagnoses and assume responsibility for these decisions and their consequent acts. They must be willing to recognize their limitations and their strengths and have the security to seek consultation, without sub-

servience, from other professionals, such as the psychiatrist and the psychologist. And finally, there must be an available untapped clientele who are aware of the service potential and are willing and capable of paying for it.

What we are saying then, directly and by implication, is that a profession is ready to support private practice when it has reached maturity. Conversely, the development of private practice is an indication that a profession has reached maturity.

WHO GOES TO PRIVATE PRACTITIONER?

The question usually presented when one reaches this point in discussing private practice is, "Who will go to a social worker practicing privately? Why pay a sizable fee to a caseworker, when you can receive the same or comparable service from an agency, perhaps from the same worker, free or at least at a considerably reduced rate?" This type of question illustrates an inability to comprehend our cultural and social patterns, a misunderstanding of human behavior, or a rejection of the evidences of maturity within our profession. People seek a private social worker as against the use of the agency for exactly the same reasons they select a private physician over a hospital clinic.

There is a generally accepted tenet that one gets what one pays for, and that anything free cannot be too good. A sizable group of people will shun a free service that they will gladly accept when a fee is attached. In addition, there is a widely held belief that social agencies are intended for the use of the poor, which is extended by the annual appeal for funds and public contributions. For a large segment of our society, accepting the services of a social agency is next to impossible. This is true not only of individuals needing the services, but also of those groups from whom we expect referrals and to whom we attribute a degree of sophistication, for instance,

physicians, attorneys, and the like. As a result, study after study has demonstrated that case loads are drawn primarily from the lower-income groups.

Then there is the question of confidentiality. For a large number of people the consideration of receiving treatment within an agency setting is unthinkable. They rebel against the thought of a caseworker's sharing their family and personal problems with a supervisor or more generally in staff conference. To have their names placed in the Social Service Index is completely repugnant. They can never feel comfortable walking in and out of an agency door where they may be seen by friends and acquaintances and perhaps members of their own social group. Again this refers not only to potential clients, but also to professionals who desire to make referrals but who hesitate to send certain of their patients to agencies. It is useless to complain that it should not be this way, for at the moment it is a fact. Indeed, how many caseworkers would refer members of their own family to the agency at which they are employed? Or how many would refer family members even to other agencies where they are well known and with whose workers they come into contact almost daily?

Next is the problem of agency function as it affects intake. People are not born and bred along the lines of functions of social agencies. Some of them present problems and conditions that are not acceptable to the local agencies for treatment, since they are outside agency function. It is right and proper, and extremely necessary, that each agency clearly define its functions and accept for treatment only those who fall within these well-constructed rules and limits. But this always excludes groups that need social work services and are asking for them. For example, they may live outside the United Fund area; or they may fall into age groups for which no treatment facility has been established.

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They may present rather rare types of problems with which no agency is prepared to cope. It may be that they are not able to comply with the time schedule of an agency or that they live in a community which does not offer the desired services. Perhaps the agency desired has such a long waiting list it does not meet the urgency of their situation. For such people, the needs can be met only through a private practitioner.

Finally, private practice enables the client to select a social worker of his own choice. There may be many reasons for this wish, but it can be met only through private practice. No agency could ever afford, and perhaps it never should permit, such a practice. But for a vast number of clients this is of utmost importance. The medical profession has long recognized this psychological truism and has utilized it continually. At any rate, for many it permits the establishment of a relationship based on confidence and respect.

One thing is clear: regardless of the reason, clients *do* seek out private practitioners and referrals *are* made to them by other disciplines even when they are quite aware of the existence and function of social agencies.

TYPES OF PRIVATE PRACTICE

Let us turn then to the types of private practice which may be entered into, and what is available to the social worker who desires to enter into private practice. A recent survey indicated that the great majority adopt private practice on a part-time basis. That is, they continue their affiliation with an agency, clinic, or hospital, but devote evenings, Saturdays, and other free time to their own practice. Some work part time at an agency and part time on their own in varying proportions. So far, very few seek their entire income from private practice. This speaks volumes for the developmental stage of the field, the security of its workers, and the general acceptance by the public.

The social worker may enter as a general practitioner or as a specialist—completely on his own or in conjunction with someone else in the same or in an allied field. As a general practitioner, he is prepared to accept referrals of any nature where casework is indicated. These may have to do with family casework, child guidance, marital counseling, and so forth. If the decision is to specialize, the caseworker would accept only cases related to his own particular interest, let us say family casework, and refer all others, such as child guidance work, to the appropriate service.

One of the more common methods of approaching private practice is in relationship with a particular psychiatrist. When this is done, all referrals customarily come from one source. The psychiatrist does all intake and accepts all referrals from outside sources. He then makes a decision as to whether the case can be handled best by having the responsible or significant relative seen in casework. If so, he calls in the social worker for consultation and referral. From then on psychiatrist and social worker work together for the patient. This method is most frequently employed in child psychiatry, with the caseworker offering service to the parent. As psychiatrist and social worker become more and more familiar with each other's capabilities, the roles are frequently reversed. In many respects it assumes very much the character of a small independent child guidance clinic.

Social workers may work in conjunction with a pediatrician. With this type of practice all referrals usually come from one pediatrician, although there is nothing to prevent others from utilizing the service. The pattern arose from the inability of the doctor to devote sufficient time to parents, even when there were some obvious difficulties around the care and management of the child. The pediatrician may become aware of emotional factors which he is not equipped to handle, either by training or experience. When the referral is made, the

operation may resemble the service in a hospital pediatric service.

If the caseworker establishes a practice completely independent of any association with a specific referring source, then the case load is apt to be much more diversified. Referrals may come from psychiatrists, pediatricians, general practitioners, school teachers, clergymen, lawyers, and from the clients themselves. This frequently attracts many family and marital problems. Because of the frequent necessity of seeing more than one member of a family, social workers often associate themselves with another worker in establishing a practice.

TYPES OF REFERRALS

Fred was a 15-year-old boy at the time of referral and was referred directly by his parents. They were concerned because of his extremely poor school performance which threatened not only to force him out of the college preparatory course in high school, but even to eliminate him from high school. It developed that the boy was rather immature and did not relate well to other children. He was constantly attacking a younger sister and disliked his younger brother. He was very critical of his mother. There was an open hostility between father and son, with Fred frequently provoking difficulties and reacting in a hurt manner when his father retaliated. He rebelled against every limit placed on his freedom of action.

Fred was referred for psychological testing and achieved an IQ of 148. This demonstrated that he was intellectually capable of doing the school work and his difficulties lay in another direction. Projective tests revealed a boy with strong unmet dependency needs, jealous of his father's position in the household and resentful of any attention given his siblings. Casework given on a once-a-week basis substantiated these findings and indicated his methods of arbitrating his own needs and the demands

of his parents. Contrary to initial expectations, his chief defense and weapon was a kind of passive resistance. Not doing homework and failing in school struck his father in his most vulnerable spot. The more pressure the father brought to bear, the worse Fred did. Since the major portion of conflict revolved around the father, he was in casework by another worker.

It was possible, after some time, to get both father and son to relax the hostile-dependent relationship enough so that referral could be made to an out-of-state boarding school, but where Fred could visit home at least once a month. This was felt necessary to relieve the tension for both and free Fred to advance in school. The boy was able to appreciate his hostility, to perceive the provocativeness of his behavior and the inconsistency of his actions. With the support of the caseworker he accepted boarding school placement. At this point, Fred is a freshman in college and continues to see the caseworker on occasion as he has for the past two years, using him as benign father figure. The family reports that relationships at home are much more cordial.

In a second case, Dr. Jackson was a leader in a small community and chairman of the school board. Referral was made by a psychiatrist who was treating his wife. She was beginning to demonstrate symptoms of paranoid schizophrenia. Dr. Jackson was essentially a rather passive person who was utterly confused by the turn of events. He had difficulty grasping the fact that his wife was sick rather than being an unbearable, nagging shrew who detested him. Further, the constant verbal barrage emanating from his wife's crystallizing delusional system, coupled with his own passiveness and uncertainty, had begun to convince him that his personality and his actions were responsible for her condition. He had become somewhat withdrawn, depressed, and harried; he suffered stomach upsets and his business and income had begun to deteriorate.

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He was enabled to understand and appreciate the meaning and the nature of his wife's illness. He could eventually participate in plans for her hospitalization as a positive treatment of an illness rather than a punitive measure. When the question of divorce arose, he handled his ambivalence and religious convictions leading to separate maintenance and adequate provision for his wife and child. Physical symptoms have disappeared and he once again has regained his position as a leading, public-spirited professional in his community.

A third case was that of Miss Mason referred by a social worker who was a personal friend. Miss Mason was a 28-year-old woman in an outlying community, a professional worker, who was approaching marriage with many misgivings. She felt that she was not sure whether she really loved her fiancé and if she could be happy with him. It quickly became apparent that her fears, anxiety, and misgivings were not

around her fiancé but around marriage, and this paralyzed her into inactivity. Her father, of whom she had been very fond, died when she was 11. In many respects her boyfriend was similar to her father and she frequently compared them. The elements of incestuous taboos and extreme guilt underlay her inability to make a decision. On the other hand, basic ego strengths were sound and intact. There was no real evidence of earlier or intense neurotic conflict. A psychiatrist was used in consultation.

After Miss Mason began to appreciate that her difficulties were based in her vague fear of marriage, rather than in her fiancé, she became quite dependent upon the caseworker. At this point, in the role of a father figure, the caseworker was able to give paternal permission to get married. Miss Mason, greatly relieved, was able to do all the necessary planning. Three years later this appears to be a happy, successful marriage.

BY JOHN J. APPLEBY, VIRGINIA C. BERKMAN,
ROBERT T. BLAZEJACK, AND VICKI S. GORTER

A Group Method of Supervision

ONE OF THE areas indigenous to social work that has been subject to much criticism is its method of supervision. Social work supervision, unlike that of other professions, is characterized by the continued dependence of an experienced practitioner on a supervisor. Rochelle Indelman points out that the profession of social work fails to apply to itself one of its basic principles, that of confidence in the ability of the human being to separate himself from a helping relationship.¹ The need for the social work practitioner to become more mature, responsible, and independent is recognized, but the very system he operates in may not meet this need.

This dilemma of supervision in social work practice has been discussed for many years in the literature. As social agencies have begun to experiment with new approaches to supervision, reports of these variations have appeared in professional journals. One such article is the excellent report of the experience of the Boys and Girls Aid Society of Oregon with self-determined use of peer consultation.²

The present paper reports the experience in establishing a group method of super-

vision by the social service staff of a Veterans Administration neuropsychiatric hospital.³ This procedure was introduced in June 1957. Briefly, the new method involves the meeting of staff members in groups to discuss their professional problems. The supervisory position is dispensed with, and the groups and administrator share the traditional supervisory functions. This differs from other group supervisory methods which retain the supervisor-worker relationship.

Historically, several factors motivated and facilitated the transition from individual to group supervision. All staff members had had considerable professional casework experience; all had participated extensively on staff committees; and many had functioned as group leaders in the hospital's group therapy program. Also, for six months prior to the change in supervisory method, the home care workers had functioned without supervision. In addition, during a three-year period, one of the supervisors had supplemented weekly individual conferences with semimonthly group meetings with her supervisees. Furthermore,

¹ "Supervision and the Advanced Practitioner," *Social Work Journal*, Vol. 36, No. 1 (January 1955), p. 18.

² Ruth Newton Stevens and Fred A. Hutchinson, "A New Concept of Supervision Is Tested," *Social Work*, Vol. I, No. 3 (July 1956), pp. 50-55.

³ The Veterans Administration Hospital, Palo Alto, California, is a 1,400 bed neuropsychiatric hospital. The social service staff consists of a chief, assistant chief, research social worker, two home care workers, training supervisor, and seven case-workers.

JOHN J. APPLEBY, M.S.W., is clinical social worker; **VIRGINIA C. BERKMAN, M.S.W.**, is research social worker; **ROBERT T. BLAZEJACK, M.S.W.**, is home care social worker; and **VICKI S. GORTER, M.S.**, is training supervisor at the Veterans Administration Hospital, Palo Alto, California. This paper, written jointly by the authors, was presented at the 1958 National Conference on Social Welfare by Mrs. Berkman in Chicago in May of this year.

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the Veterans Administration established a new classification for the caseworker whose performance reflects a high degree of skill and independence.

These factors, along with the staff's questioning of traditional social work supervision, prepared the way for a break with the past. Since the agency was strongly oriented to the use of groups as a treatment method, it was not surprising that the direction of change was from individual supervision to a group method.

Having selected the technique, the staff appointed a committee to determine the composition of the groups. An attempt was made by this committee to represent the major social service assignments in each group. Three groups of four members each were formed, with the administrator as an additional member in every group. For several reasons, it was decided that the administrator's inclusion was essential. First, the administrator needs to be familiar with the problems faced by the staff in order to make effective administrative decisions; secondly, he needs to be aware of each worker's performance; and, thirdly, the discussion of ideas and problems between the administrator and staff members creates an atmosphere of mutual understanding. The staff decided that there would be no designated leaders in the groups and that the administrator would be regarded as much as possible as a peer. Groups were to meet for approximately one and a half hours each week. The use of this time was to be left to the discretion of the members.

Before having experience with this method, the staff thought that group membership might be changed periodically. However, as group identity developed, members did not want to change.⁴

Since the groups themselves could not meet every consultative need of the staff members, individual peer consultation be-

came a necessary supplement to the groups. It is common knowledge that informal discussion of cases between workers takes place under the system of individual supervision. However, such discussions often create considerable guilt about by-passing the supervisor. By freeing the worker of this feeling, constructive use of fellow workers for consultative purposes became acceptable. Staff members now assume the responsibility for seeking out a peer or administrator for consultation on a professional matter. The limits to this procedure are those set by the individuals involved. The worker selects as consultant the person he feels can be of most help to him. The person whose assistance is requested evaluates the problem and decides what he can offer and if he has the time available. It is believed that serving as a consultant gives the worker an opportunity to develop teaching skills, and to increase his knowledge of case situations.

PROS AND CONS

A shift from a method so much a part of social work practice as individual supervision necessarily leads to a desire to compare the new with the old. There is a tendency for the proponents of any new system to want to compare the good qualities of their method with the faults of the old method. The present paper attempts to avoid this by reporting positive and negative aspects of the group method which can be compared with any individual supervisory experience.

The group method requires of the worker greater responsibility for learning and introduces a new responsibility—that of teaching. Under individual supervision the worker has the responsibility to learn but can rely on the supervisor to provide some of the stimulus and motivation. Under the group method motivation for learning must come from the worker. In the group situation learning takes place not only while the worker's own specific problems are being discussed by the group, but also, while he is listening or actively participating in seeking solutions to the problems of others. In

⁴One of the difficulties of the group method is the assimilation of new staff members into a well-established group. This problem has not arisen, but possible solutions are being discussed by the staff.

the course of exchanging ideas in a group the emergence of the worker as a teacher takes place. Teaching and learning become interrelated in the group process and hopefully enrich the worker's perception of his job.

Under individual supervision the worker may depend upon the supervisor to help in making decisions. Because there is no supervisor in the group method and because the groups meet only once a week, the worker is placed in a position of responsible independence. He must make his own decisions, and even though he may ask the group for help, the responsibility for these decisions is his alone. Under these conditions the worker should develop greater skill in analyzing case situations and carrying out treatment planning. This, in turn, helps the worker become more self-reliant.

In individual supervision it is not uncommon for the supervisory relationship to be blamed for the worker's professional difficulties. For example, the worker may use a personality conflict with the supervisor as an excuse for his poor professional performance; or, the supervisor may attribute the worker's difficulties to his inability to accept an authority figure. Under the group method, responsibility for his performance lies squarely with the caseworker. When responsibility is placed on the worker, an increase in maturity should result.

The group method enables an individual worker to communicate to other members of his group knowledge and skill in those areas of social work practice in which he has special competence. One worker may have considerable knowledge about group therapy techniques, a second may be skilled in working with alcoholic patients, a third may be able to establish productive team relationships. Recognition of these skills by the group members stimulates the worker to further development of his special capabilities. Under individual supervision the opportunity for such communication and staff recognition is usually limited to

informal discussions or occasional staff meetings.

The group method affords an opportunity to the worker to test his ideas on a number of caseworkers with a variety of experiences. The broad range of perception and experience offered by four workers is usually greater than that offered by a single supervisor. Though the variety of opinions and evaluations verbalized in a group meeting may tend to confuse the worker at times, the value of a number of thoughtful comments seems to counterbalance this difficulty.

The supervisory process with its adherence to the concept of confidentiality limits the worker's opportunity to understand the differing responsibilities and pressures of his peers and administrators. This is especially true in an agency where workers are performing different duties. The group method makes possible a better appreciation of the differences of other workers' jobs and, by doing so, builds awareness and understanding of the functioning of the agency as a whole.

Under the traditional system, the supervisor is charged with responsibility for the worker's performance and the maintenance of agency standards. In the group method, no individual's professional status is dependent upon the competence of a co-worker. Responsibility for setting and evaluating standards is shared by the group.

The authors believe that the group method has helped staff members to resolve interpersonal difficulties which arise on the job. These difficulties can be brought to the group for discussion by those involved, and their resolution becomes a group responsibility. As there is no longer a supervisor who may be seen as responsible for handling these difficulties, staff members deal with them more directly.

The question may be asked, "Is group supervision less anxiety provoking than one-to-one supervision?" The group situation may be less intense, less exhausting emotionally, but perhaps as complex or

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more complex than individual supervision. The anxieties which arise from one-to-one supervision are replaced by other difficulties, such as the discomfort of exposing oneself to criticism before a group of peers.

One of the weaknesses of the group method is that a worker cannot receive the amount of individual attention he would get in conference with a supervisor. It is difficult for the group to have as intimate a knowledge of the worker's cases as an individual supervisor would have. Furthermore the group may not be able to provide sustained attention to a particular worker's problem or to an individual case. Peer consultation, as an adjunct to the groups, may partially offset this handicap.

A NEW SET OF PROBLEMS

While overcoming some of the disadvantages of individual supervision, the use of the group method introduces a new set of problems. Since group members differ in their abilities, capacities, and needs, the benefits the members derive from the group also differ. It is possible to speculate about the effects of group composition. In a heterogeneous group the pace of the group's discussion is determined by the efforts of the workers to establish a common meeting ground. If the pace is too fast, the less skilled worker may feel left out. If the pace is too slow, the more skilled worker may feel frustrated. However, a common basis of discussion is necessary for effective group functioning, and the worker who is slowed down is free to use peer consultation.

Another problem introduced by using the group method is the possibility of stifling individual growth and learning for the sake of maintaining harmonious group relationships. The solution to this problem places two demands upon a group member: one, that he reveal as honestly as possible his professional performance to the group; and, two, that he participate in being constructively critical of the performance of others.

The first of these demands is less threatening for the secure worker when he brings

his work to the attention of the group. This worker is generally able to deal with the discomfort of having more than one person know of and point out limitations in his professional practice. The group's supportive and constructive manner of discussing what this worker has presented is observed by the less secure worker. This experience may then enable him to feel less reluctant to share his experiences and reveal his limitations.

For several reasons the group members usually find that the second demand, that of offering professional guidance and criticism to co-workers, is their most difficult task. First of all, most staff members have little experience in judging the work of their colleagues. Secondly, group members are reluctant to offer criticism because of the feelings which they might evoke in those being criticized. The situation is equally uncomfortable whether the person being criticized reacts by turning his feelings against himself or the critic. Thirdly, group tension is generated by such a situation. Since the less secure worker is more likely to become threatened in the face of criticism, it is to this worker that the group is most sensitive and around whom revolves the choice of group harmony at the expense of individual growth.

If the group does not choose to confront the worker, it maintains group harmony at the expense of its primary purpose—that of education and professional growth. By choosing such a way out, the group members also do not help the worker who feels threatened. However, as time goes on, members tend to become identified with the group, and as this happens, they feel less discomfort about confronting each other. Throughout this process a worker does learn to be supportive and, at the same time, professionally critical.

There are workers who, for a variety of reasons, have not been able to benefit from individual supervision. For some of them, effective learning can take place by use of the group method. But it cannot be claimed

that this method will help all workers. This, however, should not be used as a rationale for condemning the group method—for no one technique of supervision can be beneficial to every individual.

As the method has been described, the members have the responsibility of using their group meetings as they see fit. In practice, the fact that the groups had no precedent by which to decide their function or to measure their progress led to uncertainty as to how to make use of their time. The administrator's presence in the groups and the realization he could not avoid making comparisons between them increased the members' motivation to use the time profitably.

The three groups became unique in character, each using its time in slightly different ways. One group began early discussing individual case situations and casework techniques; another discussed in greater detail theoretical and policy-making questions; and the third spent considerable time exploring how members in this group could work effectively together.

FORMER DUTIES OF SUPERVISOR

With the termination of individual supervision, there is a necessary redistribution of the responsibilities formerly held by the supervisor. When the group method went into effect, the groups took over the educational functions formerly assigned the supervisor, while the administrator took over duties such as approving outgoing correspondence, reviewing over-all case loads, and evaluating the worker's performance.

In operation, this division of function becomes more complicated and necessitates continued redefinition. For example, a problem can arise, such as that of the worker whose questionable performance is administratively apparent, but who does not bring his difficulties to the group. As a first step, it was decided that such a worker and the administrator should discuss these difficulties in private and that the worker would be strongly urged to seek the group's

assistance. If he did not, individual help would be made available to him.

Even though the administrator's presence was considered essential in each group, his inclusion has created some problems. The administrator has two roles, that of peer in the group and that of executive of the service. Viewing the administrator as a peer in the groups has been difficult at times for the staff. It is easier to do so when he seeks help with his own casework and administrative problems. It becomes more difficult when the workers present their problems, since they know that some evaluation of their work by the administrator takes place. Also, the workers may tend to place more importance on his comments than those voiced by their peers. Then, too, his case comments may deal in part with policy matters, and at such times he may act as the executive. The members, therefore, may sometimes be confused as to which role the administrator is assuming.

Another problem related to the administrator's presence in the group is that members may expect leadership to come from him. Therefore, his presence may hinder members with leadership potential from demonstrating this ability. This situation is one the workers and the administrator are well aware of and are attempting to guard against, since one of the stated objectives of the group system is to provide the atmosphere and opportunity for development of leadership on the worker level.

CONCLUSION

A description and evaluation of a group method of supervision have been presented. There are difficulties inherent in an appraisal made by those involved in the method, particularly at a time when the method is still in its infancy and enthusiasm is especially high. The first step has been taken—the hardest one—the break with traditional supervision. Undoubtedly, there will be changes as the method develops, but a healthy and worthwhile start has been made.

BY YONATA FELDMAN

A Casework Approach Toward Understanding Parents of Emotionally Disturbed Children

THE MOST CHARACTERISTIC part of human behavior is that though biologically determined, it lends itself to most radical modifications through nurture. All attempts to influence behavior, all forms of psychological intervention, all forms of psychotherapy are based on this premise. Studies in parent-child relationships have more and more revealed the deep and all-important tie of parent and child. It has been accepted that the parental influence on the child is exerted not so much by what the parent does or says, but by what the parent is—in other words, that the parent's total behavior, both conscious and unconscious, has a profound influence on the child.¹

However, in our understanding of a particular parent in a child guidance setting, practice is not always attuned to our theoretical knowledge. In practice we often base our understanding of the parent-child relationship on information obtained from the parent in but a few interviews. The techniques usually applied to investigate the unconscious motivations are often overlooked and not even considered necessary for the understanding of parental influences. We are too often satisfied with a factual description of parental handling, looking at and taking into consideration the visible part of the iceberg without giving

sufficient weight to the larger part submerged under water. On the basis of fragmentary information, we often build the whole plan of treatment for the child and for the parent.

It is very difficult to figure out what determined the slowly changing practice, still customary in many child guidance clinics, that the children are treated by the most competent in the investigation of unconscious motivations, the psychiatrist and psychoanalyst, while the parents, even those whose behavior is definitely diagnosed pathological, are assigned to caseworkers.²

The questions we must ask ourselves are: Can parents really change their fundamental attitude toward their children unless we fully understand not only what they do and what they say, but also who they are? Can children, even with the most skilled direct therapy, gain enough strength to counteract subtle, yet powerful parental attitudes—attitudes of which the parents themselves are not aware?

Yet involving a parent in a type of relationship that lends itself to the investiga-

¹ Adelaide M. Johnson, M.D., "Sanction for Superego Lacunae of Adolescents," *Searchlights on Delinquency* (New York: International Universities Press, Inc., 1949), p. 225.

Marianne Kris, "The Use of Prediction in a Longitudinal Study," *The Psychoanalytic Study of the Child*, Vol. 12 (New York: International Universities Press, Inc., 1957), p. 175.

² Leona M. Hambrecht, "Psychiatric Social Casework with Children," *Modern Trends in Child Psychiatry* (New York: International Universities Press, Inc., 1945), p. 307.

YONATA FELDMAN, M.A., is borough supervisor of the Bronx office of the Madeleine Borg Child Guidance Institute of the Jewish Board of Guardians, New York, N. Y.

tion of unconscious motivations is often the most difficult task. Such a relationship requires the person's acceptance of a problem within himself and a willingness to participate in a process, the partial aim of which is to reveal the cause of the difficulty—something which the parents in child guidance clinics are apparently unable to face.

With the increasing general acceptance of mental hygiene concepts, a larger number of parents find enough courage to seek treatment for their children. They usually are not aware that they have contributed to their child's problem. During the intake interview, under the impact of the traumatic event that brought them to the clinic and under the influence of recalling to memory the history of the child's difficulty which they are asked to relate, parents might be forcefully confronted with the role they played in the child's problem and might then blame themselves. This insight, however, is only of a momentary nature. This is only a peripheral understanding that cannot be accepted or tolerated too long. Carried away with the parents' statement of their own problems and thoroughly agreeing with it, workers have often referred the parents to treatment resources for adults. A follow-up of such referrals has shown that many parents never applied but only went once or twice and never returned. In numerous cases, when parents were told too quickly that, in addition to the child, they also needed treatment, they left the clinic never to return. The worker's too quick acceptance that the parents themselves were in need of treatment was so frightening that they withdrew both the child and themselves from any offer of help.

If this is true of parents who seek help for their children—parents who are willing to sacrifice and even pay a fee—how about those parents who come to clinics and agencies only through community pressures? These parents are not ready to accept help, either for their child or for themselves, not even after their child has gotten into seri-

ous difficulty with himself and the law. Yet this is the group of children and parents whose need for help is greatest. This group constitutes a focus of infection that must be given serious consideration if we wish to work toward prevention of emotional and mental disturbances. We are all familiar with the classical statement: "Client unco-operative—case closed." It is still a popular statement. In child guidance clinics one often sees an additional statement—that the child has improved, that treatment of the child progressed properly, but the parents interrupted treatment and withdrew the child.

Because it is so important to successful treatment of the child that his parents should participate fully, should not put obstacles in the way of treatment, and should not interrupt treatment, a group of case-workers at the Madeleine Borg Child Guidance Institute of the Jewish Board of Guardians have given special attention to the treatment of parents. This paper is based on their and the author's own experience with parents of emotionally disturbed children. It is based also on the study of records on treatment of parents by colleagues in other child guidance clinics and agencies.

ACCEPTING HELP VIA THE CHILD

When we analyze the records of parents who bring their children for treatment to a child guidance clinic, we find that some do not see the need of coming themselves, beyond making the complaint and giving the history. With such parents the worker has to formulate a reason, acceptable to them, why it is desirable for the parent to continue coming regularly. These parents are full of fears that a request for regular interviews on the part of the worker is a form of putting the blame on them and that this is a form of punishment. Sometimes their defense against treatment is very strong and cannot be resolved in the initial contacts. Then their wish not to participate must be respected. Treatment must be

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started with the child and through the child one must attempt to reach the parents.

Some parents are willing to come to the clinic regularly only to impress upon the worker how difficult the child is and how much trouble he causes them. They urge the worker to do something immediately to relieve the situation. Some parents know that some specific handling of the child is indicated and want to learn how to handle the child through specific advice. Some parents go so far as to say that they wish to understand why their child has developed an emotional disturbance, to learn the cause of the difficulty, and to eliminate the cause.

Whatever the parent's reason for coming to the clinic, when he consents to come and we listen to his repeated story of the child's difficulties, sooner or later we become aware that the parent, too, is emotionally disturbed now or was emotionally disturbed as a child, and that his or her difficulties are very similar to the child's. The more we study the parent, the more we see the similarity of the disturbance. Often the disturbance of the parent is still quite severe. The parents as well as the children have phobias, sleep disturbances, feeding problems, are withdrawn, have no friends, and so on. Usually these difficulties have their origin in the parents' early childhood. The parents themselves tell us about these difficulties and one cannot help but ponder the fact that they never sought help for themselves, and if confronted with such a possibility, would shy away and withdraw the child and themselves from treatment. They do not seem to be able to accept help for themselves, but can only do so via their child. In this sense, then, it would seem that to a certain group of emotionally disturbed people, their child becomes the medium through which they express their symptoms and through which they can accept help.

When we examine this group of people more closely, we see that they have this in common—they are extremely sensitive.

They cannot face their own feeling of being damaged. Often mothers or fathers feel damaged to a degree where they fear loss of control and insanity. They say, "If you do not help my child to behave in a hurry, I will have a mental breakdown!" This is the phrase often heard at the time of application for service. These characteristics are particularly true of the parents who do not seek help for their children on their own, but who are propelled into treatment by outside pressures. Such parents are not integrated enough to admit a problem, to seek help, and to accept certain conditions necessary to maintain treatment.

PARALLEL PROBLEMS

In analyzing many records of mothers and fathers and their children, and in comparing the material of parent and child given in the interviews and following the trends in the respective treatment processes, one is struck by the parallelism of the problem presented by both parent and child. For instance: Richard in his first interview expresses unusual curiosity. He looks through the worker's desk drawers, under the table, and so on. Richard's important symptom is blinking of the eye. His mother keeps asking, "What goes on in Richard's interviews?" She would like to be present to see whether Richard is behaving and what the worker is doing with Richard. Both mother and son reveal their sexual curiosity—a desire to look at the forbidden. Both feel guilty about it.

Many records show that the son will start treatment by boasting of his abilities and powers, will later admit his feeling of inferiority, and will then move on to reveal his castration fears. His mother will start treatment by showing her disappointment in being assigned to a social worker, who is not good enough. She will later reveal her feeling that women are inferior and her image of herself as damaged and worthless.

The orthodox Rabbi R brings his 14-year-old son to the clinic because the boy refuses to attend a parochial school and

revolts against his father's wish for him to grow up a pious Jew and a learned rabbi. To make sure the boy is not truanting, the father follows him as he leaves the home to go to school. The boy's clever tricks to dodge the father and the father's maneuvers to outsmart the boy occupy many interview hours of both. It is obvious from the way he relates his story that the father enjoys the chase. While preoccupied with saving his son, the rabbi neglects his own duties and gets into trouble with his congregation. Later, treatment reveals that pleasure-seeking and revolt against the Ten Commandments are the basic problems of both father and son.

Mrs. B complains that Susan is withdrawn. She refuses to leave the house because she fears strange men. Later in the same interview, Mrs. B states that she must take Susan to school and call for her because the girl has to pass a garage. Mrs. B knows that garages are full of "degenerates" and she fears they will rape Susan.

A frantic phone call from Mrs. W—her 6-year-old daughter, Fanny, is beyond her endurance. She constantly *whines, screams, and fights*. She drives her crazy. Because Mrs. W is so upset, an interview is given her at once. She arrives at the clinic with her husband and her three children. Fanny is the middle child. The worker interviews both parents while the children play in the waiting room. In the interview the father holds the floor while the mother is mute. Even when approached directly she says nothing. The father says Fanny is a good child with everybody except her mother. With the mother, she *chatters constantly*; tells her mother she is unhappy because she feels unloved. The worker remarks that it is difficult to be the middle child. Suddenly the mother takes over the interview. She was a middle child, she says. She never dared to *open her mouth*. She was dominated and abused. Mrs. W then reveals that she had applied to the clinic two years before. She had been referred to an adult clinic but never went there. She feels ill—

she is hoarse—she has fears she has cancer. Here we see the mother's repressed oral activity being expressed through the child's symptoms.

As treatment of parents progresses, they reveal traumatic experiences in their own early childhood. Early primitive strivings are kept in check only with the greatest expenditure of energy—sometimes through severe obsessive-compulsive behavior and sometimes through isolation and withdrawal.³ Somehow they are able to manage through part of their lives. Often the routine of a job makes their existence possible and checks anxiety from becoming overwhelming. However, when these individuals marry and have children, their problems are recreated. The normal developmental stages of the infant and growing child reactivates in them the same state of anxiety they had at this stage of their own development. Driven by anxiety, they become extremely punitive to the child for fear that the child will not be able successfully to outgrow this particular stage of development which they themselves were unable to master. Or else, in fear of their own aggressive or seductive wishes, and to protect the child, they withdraw from the child *emotionally*. When a parent thus withdraws from the child in his first years of life, the child has little opportunity to form a meaningful object relationship, and is almost as badly off as if he were to grow up without a parent. Thus it is that the parent's anxiety in reaction to a certain developmental stage in the child overstimulates or understimulates the child and produces the same problem in the child as the parent had—often in a much more exaggerated form.⁴

³ Leo Nagelberg, Hyman Spotnitz, M.D., and Yonata Feldman, "The Attempt at Healthy Insulation in the Withdrawn Child," *American Journal of Orthopsychiatry*, Vol. 23, No. 2 (April 1953), p. 238.

⁴ Hyman Spotnitz, M.D., Leo Nagelberg, and Yonata Feldman, "Ego Re-enforcement in the Schizophrenic Child," *American Journal of Orthopsychiatry*, Vol. 26, No. 1 (January 1956), p. 146.

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DOUBLE MEANING

From the above, one can then make the assumption that when a parent comes to discuss the problems of his child, with whom he can no longer cope, his statements have a double meaning. Though on the one hand he realistically describes the conduct and emotions of his child, unbeknownst to himself he describes his own problems. It is interesting to note that this often appears very early in the contacts in an indirect statement or a denial. For instance, Mr. R's son is brought into court for stealing. He is referred by the court to the clinic. The father resents the referral and is angry with the probation officer. He says he hates the probation officer because he "handled me like a criminal. I am an honest man and the whole neighborhood can testify to this!" Later in treatment the father reveals that he had strong impulses to steal as a child. Mrs. F complains that Sam kisses his dog. When she sees him on the floor playing with the dog, she loses all control. She steps on him and beats him mercilessly. Later in treatment, she remembers masturbating animals when she was a child and her fear of perversion.

Mrs. X refers her 4-year-old for extreme violence and abusive language. She wonders where a child so young could have learned this. At the end of the interview she apologizes to the worker for having been late for the interview. In anger she had thrown a bottle of milk at her husband. The bottle accidentally went through the window and the superintendent of the building made a fuss about this, thus detaining her.

It is important to understand the double meaning of the parents' complaints about their children. Workers often take these complaints literally and are influenced in a negative way. They react negatively toward parents who betray such hostile feelings and acts toward their children. The worker's feeling of disgust and abnormality is transmitted to the parents. Even if it is not expressed verbally by the worker, this

may tend to support the parents' image of themselves as being abnormal and damaged and to create greater anxiety for them. The worker's attempts to give advice on how to handle the child-patient may have the same effect. The parents may react to this as a criticism no matter how diplomatically it is conveyed and the worker may be surprised to see that the advice is not carried out, or is carried out in such a fashion as to defeat its purpose.

However, if the worker understands that the parent is not only talking about his child but is also talking about his own forbidden aggressive or libidinal impulses (which he hates and wishes to get rid of), that the parent is using the child as a medium to convey his or her unconscious striving, emotional needs, primitive wishes, frustrations and fears—then the worker will react, not by giving advice on how to handle the child, but will gear her activity to assuming a certain attitude toward these strivings. The proper attitude on the part of the worker would then be the therapeutic agent leading on the road toward cure. What happened to *these* parents in the past was that *their* parents did not understand *their* emotional needs. The worker, by proving to the parents that their emotional needs are now understood, will provide an emotional experience which will be constructive in its nature. Understanding is the only form of love a social worker can give to a client, and, when we think of it, the only parental love that is conducive to normal growth and development is the love that goes with profound understanding of the child's needs. The following example might serve as an illustration.⁵

Mrs. B brings her 11-year-old son Leo to the clinic for failure in school. He has a reading disability. He is engaged in fights with other pupils and is often beaten by them. At home she cannot tolerate Leo because he is a glutton. He never stops eating.

⁵ This example is only one episode from a total treatment case.

He eats the food prepared for the rest of the family and constantly asks for more food. Mrs. B herself is a very stout woman. Leo has other serious problems, but in the beginning of contact, Mrs. B continues to dwell in interview after interview on the boy's excessive eating. Her nagging, scoldings, and punishment of the boy lead to no results except greater defiance. Talking about food, the worker asks Mrs. B about her own appetite, her likes and dislikes. Mrs. B relates her attempts to diet. She starves herself. The worker questions her attempts to deny herself food; eating is a fundamental pleasure. Worker asks her what is wrong with being stout. This leads Mrs. B to reveal her unhappy childhood. Her mother chased her father out of the house after he developed an emotional disturbance. Mrs. B was so young, she never remembered her father. Her mother had told her that her father died and she was an orphan. Mrs. B was placed in a foster home where she was poorly fed. Once her foster mother made her eat some fish which the cat had dragged on the floor. (Mrs. B revealed much later in treatment that her mother worked as a cook in a restaurant, well known for its excellent food). Hour after hour Mrs. B told the worker many traumatic experiences during early childhood, many of them related to feeding. The present-day feeding of the family is also a constant topic of conversation, and the worker encourages Mrs. B to prepare food to her own liking, adding that she as the mother is the most important person in the family. After a while, Mrs. B again complains about Leo's excessive eating and now she asks her worker to advise her what to do. The worker suggests that she might experiment and try to give Leo all the food he wishes and try to buy all the things he loves to eat. Mrs. B says this would seem to her a sensible approach, worthwhile trying, but she doubts whether she could carry this out, as her mother who lives with her still does the shopping and cooking, and she is in full control of the food. She is

the one who urges Mrs. B to diet and she is the one who makes her scold Leo. In view of this, no plan for action is accepted in the interview, as the obstacle brought up by Mrs. B will need further consideration.

Two weeks later, Mrs. B tells the worker that she has persuaded her mother to go along with her plan for Leo. At first Leo ate excessively, but when the mother not only gave him permission to eat, but offered him more food to his liking, he was baffled. He asked his mother did she really mean it when she said she wishes him to enjoy his food.

A few days later Leo came crying to his mother. He said he wants to be good. He is going to work hard and he is going to get good marks in school. He asked his mother to help him by providing him with some tutoring. Leo's emotional outburst made a great impression on Mrs. B. For the first time she felt that he really meant it when he said he wishes to be good, and that there was hope for him. Tutoring was provided. From then on Leo improved steadily in school and at home. He had a reading difficulty and he began to master it. There was no longer any overeating. Many months later Mrs. B told her worker that she was gradually taking over the cooking and to her surprise, she found that she could prepare a meal as tasty as her mother's and perhaps better.

It would seem that in this case the worker's understanding about Mrs. B's oral needs and the total attitude she took about food for Mrs. B and her son constituted symbolic feeding which enabled Mrs. B to resolve her anxiety around eating and cooking.⁶

THE THERAPEUTIC PROCESS

Thus, by understanding that the parents are talking about their own childhood needs and by reacting to this need in a proper way, the worker helps them to repress and

⁶ M. A. Sechehaye, *Symbolic Realization* (New York: International Universities Press, Inc., 1952).

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control part of their primitive strivings and hopefully sublimates the other part. The worker can show the parents that certain strivings are normal and acceptable at certain stages of development but inappropriate at others.

The form which this therapeutic process takes is often that of a discussion of the child's behavior and difficulties and might therefore at times be confused with the educational process of guidance or advice-giving. In a way this approach could be called guidance because it *guides the parent through the dangerous path of his own unresolved childhood problems*. However, it is a therapeutic casework process because it addresses itself not to information on how children or this child should be reared or handled. Instead, through a discussion of the child referred, it leads up to the understanding and meeting symbolically of the emotional childhood needs of the parent.

For a large number of parents who are brought to the attention or come to the attention of child guidance clinics or agencies dealing with the emotional problems of children, this casework approach is the only one possible in the beginning of contact. Often the approach is sufficient to result in a much better parent-child relationship and to create an atmosphere in the home where the child, with the added help of individual treatment, can proceed on the road of normal growth. Sometimes this casework approach frees the parents to recognize deeper problems and enables them to accept therapy for themselves.

In order to practice this approach successfully, one needs not only all the knowledge and skill required for the practice of

any psychotherapy, but additional understanding of the meaning the client tries to convey to us about himself through talking about his child and his handling of the child. It requires a great deal of creative ability for the worker to devise a way of speaking to the parents using *their own language* and to estimate the proper timing for speaking to the parents about themselves more directly. The study of records has shown that many caseworkers have used considerable intuitive ability in this direction but further study of a more systematic approach would be desirable.

To sum up, this paper points out that parents whose children present serious mental, emotional, or behavior problems are themselves disturbed people; that their disturbance is of such a nature that it makes it impossible for them to seek help for themselves. It would seem that because of routine life conditions, these people might be able to exist without a mental break. However, when they marry and bear children, the child's development and the need to care for the child seem to reopen old wounds and to produce an emotional disturbance that is traumatic for the child. The difficulties of such parents seem to constitute a separate *syndrome* in our classification of emotional disturbances in adults and perhaps needs a different psychotherapeutic approach. Casework seems the proper approach because it is based on the practice that though the worker is *required to understand the dynamics of the client's behavior and his emotional needs*, these needs can be met by the worker both symbolically and realistically without the client's having to have a full intellectual understanding of his character structure or behavior.

BY GEORGE SHUGART

Anxiety in Siblings upon Separation

THANKS TO THE observations and researches of a number of investigators, we have become sensitive to the potentials for trauma inherent in the removal of a child from his home for hospital, institutional, or foster care placement. This awareness has led, and continues to lead, to the development of techniques calculated to provide adequate emotional cushioning to the child facing separation from the pervasive familiarity, known since birth, of father and mother, brothers and sisters, and the material insignia of his world.¹ However, just as the child separated from his family may suffer shock by his sudden divorcement from the intimacy of persons and things, so the family unit may suffer shock by the sudden disappearance of one of its members. The delicate equilibrium of complex interpersonal relationships that characterizes the family unit may be disturbed and the realignment of human forces may occasion severe stress to one or more of its members.² The very act of planning the separation of a child from his parents *ipso facto* provides to the parents a preparatory and interpretative period and the opportunity to discharge the content of feelings and thought. Moreover, we may in the process become aware of specific emotional involvements of the parents, and in order to facilitate separation or to avoid traumatization of the parents, offer them a preparatory period comparable to that provided to the child. But what of the siblings? Are we always aware of the child's meaning to his siblings and the disturbing effects separation may have upon them? And are we prone to be as careful to prepare and support them through the separation and its resultant anxieties?

GEORGE SHUGART, M.A., is chief psychiatric caseworker in the Child Psychiatry Division of St. Luke's Hospital, New York, N. Y.

In my work with families of severely disturbed young schizophrenic children requiring hospitalization for treatment, I have found that the separation experience may be as severe and its effects as prolonged for the siblings as for the patients. While the separation anxiety manifested varied in degree depending upon the amount of pathology present within the family unit, the proximate relationships to the sick child, and differences in ages and sex, nonetheless in some measure all siblings demonstrated anxiety reactions. Although immediate reference is to siblings of psychotic children, doubtlessly the same dynamics with some variations must obtain in instances involving other kinds of children removed from their families—the mentally deficient, the physically handicapped, and the socially maladjusted. I should like, therefore, to discuss separation anxiety reactions in siblings of the psychotic child as a prototype for generalizations possibly applicable to other types of handicapped children.

But first a word concerning the setting and the people under discussion. The disturbed children were patients on a twelve-bed ward within the teaching and research hospital of the University of Pittsburgh. The service was restricted to the treatment of psychotic children, preferably those without primary mental deficiency or brain injury. Ages of admission spanned three to eight years; and the treatment program was geared to the relatively withdrawn autistic, and the symbiotic child. The caseworker

¹ Ner Littner, M.D., "Traumatic Effects of Separation and Placement," *Casework Papers* 1956, (New York: Family Service Association of America, 1956).

² Peter B. Neubauer, M.D., "The Psychoanalyst's Contribution to the Family Agency," in *Psychoanalysis and Social Work* (New York: International Universities Press, 1953).

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was responsible for treatment of the parents, and psychiatric consultation was available as desired. In order to avoid easy resort to a priori assumptions regarding the role of the parents in the etiology of the child's disorder, eligibility requirements were that the family unit be intact, that the marital relationship be a fairly stable one, and that neither parent suffered a major emotional disturbance during his lifetime. Socioeconomic status of our families included several physicians and a clergyman; a small businessman and several salesmen; a city fireman and a post-office clerk; several skilled steel workers and two unskilled factory workers. One patient was an only child.

SICK CHILD MONOPOLIZES PARENTS

Presumably in all families siblings in varying amounts suffer intersibling stresses, some real, some rooted in fantasy. However, the strains, the frustrations and inequities the siblings of the emotionally disturbed child are subject to exceed by far those that might be considered usual or expected. Because the disturbed child presents a particular and therefore a special problem, he serves as a special object of focus of parental interest and attention and as a consequence his siblings are shifted to a peripheral position in parental preoccupation. The emotionally sick child cannot be ignored, nor can he be satiated by "normal" doses of attention. His behavior is provocative and intrusive, his needs imperative and consuming. He may be unable to feed, dress, or take care of his toilet needs, requiring parental time and attention to each process. Devoid of playfulness, he may be unable to occupy himself, may cling to mother demanding and whining, or disturb the household by distracting and disruptive behavior. Elaborate planning may be required to keep him occupied. Activities need to be initiated; projects conceived and put into motion; time taken from household obligations in order to provide companionship; duties neglected in order to avoid inexplicable tantrums or bouts of bizarre withdrawal. The

child's idiosyncratic departure from normal household routines at washing time, mealtime, and bedtime may require elaborate and involved effort of the parent, both in time and ingenuity, in order to obtain the child's co-operation.

Aside from the tangible claims made by the child upon parental interest, there are the emotional involvements of the parents with the child. He claims not only time but feelings and concerns. He frustrates by his inability to conform, by his irrationalities and deviation, by his indifference to parental help and solicitude. He disappoints by his failures, his limitations, his bizarre and socially unacceptable behavior. He angers by creating feelings of helplessness and hopelessness, by stirring parental feelings of guilt and inadequacy, by bringing shame and social stigma. He creates worry, agitation, and preoccupation as to what's wrong and why, and what to do, and how long will it go on. There are endless consultations with neighbors and relatives, with teachers and doctors, trips to clinics and hospitals, expenses and material deprivations.

As the sick child claims time and mind, the total effect is a relative withdrawal of parents from siblings. "He (a younger sibling) practically raised himself. I never had time for him." "What bothers me most is that I have to neglect my other children." "He's [an older sibling] been an angel; he asked for nothing and I gave him nothing." In their concern for the sick child parents may "lean over backwards" in ministering to his needs and demands and tend to become defensive vis-à-vis his siblings, insisting that frustrations of the well child are "normal" and that well children have "other resources" to fall back upon.

CAUGHT BETWEEN LOVE AND HATE

In addition to the disparities in time and attention provided the siblings, and to the atmosphere of special concern given to the one child, siblings may suffer indignities and deprivations directly or indirectly at the hands of the disturbed one. They may

be obliged to suffer physical abuse by being struck, beaten, scratched, teased, or thwarted without comparable retaliation because of parental protection of the sick child. Their belongings may be scattered, their playthings destroyed and their play disrupted, their time forfeited to amuse the sick one, their rightful advantage surrendered so that they must indulge in defensive and self-protective maneuvers at every point to counteract the persecution of the sick child and indirectly of the parents. "He gets into everything; his brothers can't keep a thing." "He tears their [school] workbooks up." "He gets into his sister's room and pulls everything apart." "We make his brother give in to him."

Siblings' efforts to relate, to play or talk with the disturbed child may be met with frustration and failure. They may be rebuffed or ignored as the child turns his back upon their advances or responds with inappropriate behavior or verbalizations or resists their efforts to obtain some satisfactory response. "Damn you," cried a younger sibling to his brother who indulged in repetitious verbalizations. "Why don't you talk to me?" "I can't play with him; he don't know how." "I tell him but he can't listen." "He never answers me." As a consequence they come to ignore the disturbed child out of recognition that a satisfactory response will not be forthcoming; or else come to indulge him as if he were an infant by engaging him in gross muscular or tickling play.

An additional burden may fall upon the siblings in their relationship to the world outside the immediate family. Aware as they are that something is wrong both by virtue of their direct experience and the concern of the parents, they may be required to defend the sick child from the gibes of attacks of other children. The taunt, "Your brother is crazy," places siblings in an unenviable position in which they must rise to deny an accusation they feel to be the truth. They feel shame. "They call him names and they won't listen when I tell them he can't help

it." "They call him dummy, but he's really smart when he wants to be." "He acts crazy." They become the child's defenders, shielding him from physical abuse of other children. One 4-year-old carefully guarded his 8-year-old schizophrenic brother, savagely attacking anyone who dared to molest him.

As a consequence of these experiences, the formation of conflicting feelings toward the sick child takes place. At one level positive feelings and identifications are operative as the sick child is a close familiar person, as he is a brother, and as he is thought to be loved by the parents and an object of their greatest concern. At another level, there is resentment and hate because of the personal affronts and the prior claim which the sick child makes upon the parents. Envy of this attention supported by their personal discomforts gives rise to wishes for the child's removal, and in the young sibling to death wishes. Caught between love and hate, siblings may consequently face traumatization when the sick child is removed from the home and placed in a hospital or institution and react with marked anxiety, the primary sources of which are fear and guilt.

The quantities of fear and guilt siblings may experience depend upon a number of factors operating within the family unit. Pathological relationships between parents themselves or between parents and children may render siblings more susceptible to anxiety because of poorer integration and ego strength. Sibling competition between brother and brother or brother and sister may be heightened by circumstances unique to the individual family. Competition may also be intensified by close age differences between siblings and the sick child. The male sibling who cannot work on the Oedipal problems because sick brother claims mother's complete devotion is likely to experience much hostility; while the sibling with whom the child has found the closest relationship may experience the greatest sense of loss and grief.

The most common source of fear is the

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response of siblings to their own feelings of forbidden hostility. The removal of the child may, therefore, be viewed with fright as the parents seem to act out the sibling wish and anger. Siblings will view this as a realization of their own punitive feelings with consequent dread that they are also vulnerable to the same fate. In addition to fantasy as a source of fear, feelings of vulnerability also stem from reality elements in the situation. From the siblings' point of view the sick child has been a bad child. "Bad" is the most common expletive parents apply toward the child particularly before they have received information from medical people concerning the reasons for the behavior. Hence, removal becomes synonymous with banishment, and banishment with punishment because of badness. A 3-year-old girl said of her brother, "He's going to the hospital because he's bad." Since banishment equates a loss of parental love because of badness, the same consequence may await the siblings who also have had their bouts of badness. Hence, they become fearful that at some moment the parents may decide to send them away. Following the hospitalization of Carl, Otto, his younger sibling, began to ask his mother repeatedly whether she loved him. "Of course I love you," replied mother. "Then why aren't you smiling?" asked Otto. Frances, the 6-year-old sister of a younger sibling removed from the home, unexpectedly faced her mother with great seriousness and asked, "Tell me, do you really love me?" A 4-year-old when being scolded asked, "Are you going to send me away like Tony?" An apparent act of parental aggression against one sibling mobilizes anxiety in the others.

Fear may find its origin in sibling concern that some physical harm will overcome the sick child not alone because of his badness but also because of his deficiencies. The siblings' knowledge that the child cannot cope with his environment or fend for himself arouses anticipation of catastrophe. What will happen to him becomes the paramount

concern: who will feed him? will he be beaten when he tantrums? how will people know what he wants [nonverbal autistic child]? In addition, we might expect that to the very young child banishment spells annihilation. Suddenly a sibling disappears into an unknown someplace, worse still if that someplace is a hospital. Since the psychotic child is not sick within the meaning usually ascribed to the word by children, the reason for the child's removal remains obscure and mysterious, thereby inviting frightening fantasies of death.

Feelings of guilt which occur are most often directly related to the fulfillment of the forbidden wish for the child's removal. To begin with, now that the hope for the child's removal has been effected, siblings, and particularly the younger ones, may experience contrition (and fear) at omnipotence realized. The primary affect giving rise to the wish, namely hostility, may also serve as a source for guilt feelings. Furthermore, there is the forbidden relief and pleasure contemplated and experienced through the removal of the irritating child: there will be no more parental preoccupation and attention centered upon the disturbing one; no more physical and emotional abuse; no more social discomfort. Personal pleasures may be pursued without molestation. The anticipation is that parents will now be free to be claimed and possessed. Such pleasurable feelings may not be indulged in, however, as the reality of the sick child's difficulties and his consequent banishment are considered.

Soon after the sick child is removed, the anxiety attendant upon fear and guilt becomes manifest. However, the intensity of the reaction may vary from severe to so mild as to attract little notice. Unexpectedly, the siblings may show changes in behavior, often of a pronounced character. Irritability and petulance may appear with loss of interest in usual pursuits. Marked negativism and sudden acting-out behavior may ensue with unruly, defiant, and demanding behavior. There may be regressive, infantile

reactions with clinging and whining, attempts to claim mother's attention at every turn or demonstration of distress at separation from the parents. Excessive and aggressive bids for parental attention may appear with hostility and resentment at parental resistance. An occasional sibling may make a sudden step forward.

SIBLINGS' BEHAVIOR CHANGES

Otto, age 4 when his brother, age 7, was hospitalized, was an independent, self-sufficient boy who carried himself like a somewhat older child. This brother had been disturbed since the age of 3 and Otto consequently had not been able to receive his share of parental attention or thought. "He practically raised himself," said mother. Toward his brother he had assumed the protective, solicitous role of an elder brother, sharing with the parents their concerns with brother's aberrations and deficiencies. He courageously shielded him from harm at the hands of the neighborhood children. Often he surrendered his own interests to keep brother occupied. Immediately following his brother's hospitalization, Otto became enuretic, first diurnally then nocturnally and then began to soil himself. He began to cling and whine; required mother to dress and bathe him; lost his appetite and became extremely fussy with food; and was unable to sleep, complaining of "things" being in his room from which he sought to escape by crawling into his parents' bed. He made extreme demands for parental attention and was insatiable in his request for assurance that his parents, particularly mother, loved him. He refused to leave the house for outdoor play.

Marvin was 11-years of age when his brother, age 5, was hospitalized. Marvin seemed to be a fairly stable boy who had many hobbies and enjoyed being with other boys. He seemed a bit too serious and too purposefully practical, however. He favored his brother, an extremely autistic child, with much of his time for gross muscular

play, and seemed to have accepted parental preoccupation with the sick child as necessary and understandable. Following his brother's removal from the home, Marvin began to cling close to home, offering as the reason his dissatisfaction with his friends. He abandoned his music lessons and his morning newspaper route which he had been engaged in for a year. He began to make excessive bids for the attention of his parents and when they resisted this as inappropriate for his age, he became quite defiant toward their authority.

Greta, age 4, following removal of her brother, age 10, began to show anxiety at separation from her parents. She became distraught when left with baby sitters, wept through Sunday school, and verbalized a great deal of concern for her brother's well-being in the hospital. In her play fantasies, brother was always included as if he were still at home.

Tony, age 4 when his brother, age 7, was hospitalized, was not yet toilet trained, having resisted most unequivocally mother's attempts to domesticate him. A week following brother's removal, he evinced interest in the process, and a month later was able to announce his mastery with pride.

PREPARATION OF SIBLINGS

The demonstration of anxiety in siblings of a child removed from the home apprises us that preparation of siblings for the impending event is as desirable as preparation of the child. Moreover, as the alterations in behavior patterns of the siblings may come as an unexpected and dramatic occurrence to the parents, it is of equal importance that parents be forewarned and be provided with insight and techniques for relieving sibling distress.

Preparation of siblings may be achieved through two primary procedures. First, parents may be reminded of the necessity to provide adequate preparation to the siblings. At the point of arranging plans with the parents for the admission of their child,

Social Work

Anxiety in Siblings upon Separation

they may be advised to provide full information to the siblings as to their intentions, and to discuss openly the reasons for the proposed admission and the benefits to the child they hope to gain thereby; and also to describe the institution and its personnel. They should be encouraged to keep the topic out in the open and to accept questions and possible expressions of negative feelings. Because at this juncture parents are absorbed in their own feelings of separation, they are not further burdened by anticipation of siblings' feelings and reactions. After the child is admitted, parents may then be informed of the possibility of sibling reactions occurring, why these reactions may take place, and the variety of forms in which they may appear. They may be further advised that in order to minimize sibling anxiety, it would be desirable to continue to talk openly about the child and to draw the siblings into the conversations. If possible, they should facilitate siblings' direct expressions of hostility toward the child and pleasure at his absence.

Verbal techniques may be provided to the parents to aid them in this, as: "Johnny made you very angry when he got into your things. I don't blame you; he made me angry, too. I guess you've a right to be glad he's not here." Together with such verbalizations there should be assurances that all is well with Johnny; that he is being well treated by people who love children and who know how to help him get well (grow up, speak, play, not be nervous or whatever is appropriate). Following the initial visit of the parents to the child, they may be asked to bring the siblings along on the following visit so they may see that the child is indeed alive and well.

A second procedure is a visit to the home by the caseworker prior to admission of the child. Originally I had instituted the pre-admission home visit in order to assay the home atmosphere and the nature and quality of the relationships and interactions among members of the family. (A typical visit may be of four to six hours' duration

and include the evening meal with the family.) Upon becoming aware of sibling reactions to separation, I added another dimension to the home visit, namely, that of providing tangible evidence, personification if you will, of the institution to which the child is to be removed. A point is made of spending several hours with the siblings at play and fun so that the parents may later be able to reassure them that since the child will be going to the place where "that nice man is" presumably all will be well. Thereby, the hospital loses some of its threat as the distant child is thought of in relation to a specific and friendly person to whom, in the minds of the siblings, the child has been consigned. Fears and fantasies of death may consequently be successfully minimized. (The impression this visit makes upon the siblings is noteworthy. Not only is there great anticipation at seeing me again when they visit the child, but my identification with the hospital becomes so close that most of their references to it are in my name. One might speculate that feelings of gratitude are operating.)

When preparatory measures fail to forestall or prove insufficient to overcome major anxiety reactions, counseling may be provided the parents on management of the problem. Such counseling should include interpreting sibling behavior in order to lay bare to the parents some of its dynamics. These need not be elaborate or profound; the simpler the better since parents may be confused by an unmanageable amount of unfamiliar material. Techniques toward helping the sibling with his anxiety should also be provided to the parents as required.

CASE ILLUSTRATION³

When Otto's mother, with discernible alarm reported his regressions, the worker reminded mother of earlier conversations in

³ A comprehensive description of this family is contained in "Symbiotic Aspects of a Seven-Year-Old Psychotic," by Tarlton Morrow, Jr., M.D. and Earl A. Loomis, Jr., M.D. in Gerald Caplan, M.D., ed., *Emotional Problems of Early Childhood* (New York: Basic Books, Inc., 1955).

which anticipation of behavior changes had been discussed. The point was again made that Otto was experiencing fear and guilt at his hostility toward his brother and pleasure at his removal. When mother asked why he was acting like a baby, the worker suggested that he was fearful of being overtaken by Carl's fate. He then advanced the explanation that Otto by his regressive behavior was seeking to assure himself that no harm would befall him. By becoming a baby he sought to obtain mother's protection against fantasied danger. The return to infantile ways, the demand for mother's full care and interest and the concern that she love him was his way of expressing what he felt and wanted. It was pointed out to mother that she accept his appeal literally and give him what he was seeking—her love and protection. Mother was then able to accept his regressive behavior with reduced anger and scorn and moved forward to meet most of his demands. Simultaneously, mother was provided with verbal techniques calculated to help Otto express his hostility and pleasure without fear of retaliation, and to help her reassure Otto of her positive feelings for him. Thus, when Otto sought assurance that mother loved him she affirmed that she did, adding that she also loved Carl but since Carl was nervous he was sent to the hospital for help. She was happy that Otto was not nervous and therefore would not have to be sent away. When Otto demanded to be dressed or fed, mother complied with verbal recognition of the comfort she was providing followed by the observation that she loved him as much now as when he was a baby. When Otto expressed anxiety as to what was happening to Carl, mother reassured and followed with remarks relative to the advantages Otto was experiencing at Carl's absence. With the reassurances and the opportunity provided Otto to bring his feelings into the open, within two months Otto began to take care of his own needs. Diurnal wetting ceased; and at the close of the second month, Otto for the first time since his brother's absence went outside to

play. Soon after, soiling and nocturnal wetting stopped and with these went the clinging, demanding behavior and the need for reassurances that mother loved him. Normal sleep and eating patterns were also resumed. Subsequently, there were occasional partial defections and some shifts toward negativism and defiance, but on the whole Otto held his regained position well. (A subsequent crisis was precipitated when Carl, well on his way to full recovery, was returned to his home.)

To this point, I have presented behavior changes in siblings as if they were due to separation anxiety alone. While this anxiety may be the most important element in the picture, especially insofar as young siblings are concerned, changes may also come about as normal and inevitable responses to the changed structure of the family unit. A two-child family with one child removed temporarily becomes an only-child family with the relatively neglected child moving into prime position. For a time this may create a stressful situation as parents and child attempt to contain and stabilize their altered relationships. (A comparable situation may arise when the recovered child is returned to his home.)⁴ Thus, in Marvin's case, his mother, a highly controlling woman, shifted her manipulatory needs onto him, catching him in the contradiction of seeking mother's interest yet fearing its constrictions. The latter he attempted to handle in part by his rebellious and defiant behavior. It is not always possible immediately to identify the source of behavioral changes. But one begins by assuming separation anxiety to be accountable until other factors become apparent as contributory.

⁴ See Dana G. Prugh, Elizabeth M. Staub, Harriet H. Sands, Ruth Kirschbaum, and Eleanora A. Lenihan, "A Study of the Emotional Reactions of Children and Families to Hospitalization and Illness," *American Journal of Orthopsychiatry*, Vol. 23 (January 1953), p. 98. Some instances of intensified sibling rivalry upon the return home of children hospitalized for treatment of physical ailments are noted.

BY HOWARD R. KELMAN

Social Work and Mental Retardation: Challenge or Failure?

IN THE DIAGNOSIS and treatment of the mentally retarded child, we are concerned not only with an assessment of the child's biological status, but also with an analysis of his functioning as a social being in a particular social setting. The social worker is called upon to make judgments regarding the child's abilities and limitations in this sphere, and to evaluate the complex interaction of those forces, both historic and situational, that condition the present and future courses of the child's behavior and function in the family group and the community.

For the most part, concern in this area has been limited to the harmful social consequences that the mentally retarded child has upon the family and community. Looked at in this light, earlier programs of care and training were evolved to deal with these negative social effects in an effort to lessen their consequences and to control their spread to society's advantage. In the past, this form of social management led to the isolation or exclusion of the retarded from those social institutions serving the more normal population, and in the containment of the most bothersome of the lot in huge and distant custodial institutions, cut off from the mainstream of community life.

HOWARD R. KELMAN, M.S., is instructor in pediatrics at the New York Medical College, New York City. The author wishes to express his indebtedness to Alfred Katz of the National Hemophilia Foundation for some of the major ideas developed in this paper.

It remained for more recent advances in the biological and social sciences to point out that social failure or incompetency are not *necessary* correlates of mental deficiency per se, but may, in many instances, be more the consequences of our prescribed social treatment, expectations, and management of those individuals and their families.

We can no longer speak, with scientific reverence, of the retarded as being inherently delinquent or immoral, or capable of diluting the general intelligence level of our population through an ascribed abundance of procreative abilities. Nor can we in truth regard them all as helpless and hopelessly dependent creatures, incapable of positive social adaptation, and unable to make useful, though perhaps modest, productive contributions to the community.

What is really required, then, is an understanding of the effects that family and community have in conditioning the nature and extent of the child's mental handicap and the ways in which these forces along with other influences have molded his existence as a human being. In so doing we can expect that an analysis of these factors will contribute to our understanding of the child's behavior and functioning and will enable us to select more adequate and realistic treatment goals.

We know that mental retardation is a symptom, an end product of a variety of processes with differing causes and sources. The end product, we further observe, varies also both in kind and intensity, and is for the individual neither static nor

fixed, but changes with time and with changed social opportunities, social expectations, and treatment. As a chronic impairment of function in that organ which, so to speak, regulates the individual's relationship to his environment, the need to structure and adapt the environment is itself implied and, in a sense, required.

Except for those cases of severe mental defect accompanied by observable sensory defects or visible physical stigmata, or those marked by prolonged or delayed maturation, the retarded child becomes known to us because of his failure to achieve according to some accepted social norm (e.g., in the classroom learning situation), or for behavior that is not in conformity with accepted community standards for his peer group, or for failure to handle adequately his personal and vocational affairs as an adult.

But within these given ranges of social expectations as child or as adult, there exists much variation and lack of uniformity in definition with regard to what constitutes incompetence, social failure, or normalcy.

Though there is controversy over the question of the normal distribution of "intelligence" in our population, we know that social, economic, and educational opportunities are *not* so distributed, and that the abilities and performances of individuals are to a large extent determined by the access to and the use made of these opportunities.

Can we say, too, that our testing devices, which often determine the diagnosis of mental retardation, are free of cultural and social class bias? Is the adult retardate who successfully holds down a job no longer considered to be mentally retarded as against the individual with a comparable IQ who cannot do this? Are we perhaps penalizing the aggressive child or the child of parents of simpler intelligence by consigning more of these children to institutions than the placid, less difficult children whose behavior makes them more acceptable, hence, in some way more valuable?

A child is brought to a clinic by a parent, or referred by a physician or social agency, and does not come of his own volition seeking help. The parent is concerned not only about the child's physical well-being, but is concerned, too, about the personal and social implications of the child's difficulty. The difficult struggle that many parents experience in working through their understanding of their child's handicap, their daily problems in living with him, and their ability to contribute to his well-being are greatly influenced by the nature of the professional counsel which they secure, and the fashion in which the professional person relates himself to this struggle. Indifference and brusqueness in handling the problem have added to the woes of many parents. As part of or reflecting broader community attitudes, professionals have compounded the parents' difficulties in living with and in making significant decisions regarding their child's well-being.

To recapitulate thus far, we cannot study, evaluate, or plan a treatment program for retarded children that makes sense and bears a close relationship to his real life situation without an analysis of, and reference to, those pertinent family and community factors which govern his existence as a social being.

FAMILY AND COMMUNITY INFLUENCES

In order to do this, we need to direct our attention to an analysis of the family constellation and the place of the retarded child in it, as well as his relationship to the larger community. The retarded child must be viewed as an integral part of his family group and as having distinct relationships to its members. The child, the parents, and the siblings mutually influence one another's functioning and contribute their respective influence to the dynamics of the family unit's functioning as well.

The family group and its individual members had a history and patterns of relationships prior to the birth of the retarded

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child. The impact of the retarded child on the members of the family and their interrelationships are in turn reflected in their responses to the child. Coexistent with this each family, on a consciously planned basis or perhaps more haphazardly, attempts to weigh and balance the needs of other family members and is subject to all the varied influences which affect all of us in these times.

While it is true that the impact on families and parents is not inconsiderable and is for many a profound shock, this is not to say that its effects are felt uniformly nor will all families respond to this situation in a similar fashion. The response to and reaction of the family members is itself conditioned by several interacting factors. Among these are those relating to the child's type of disability, the severity, and the social implications which may surround it. Is the child a mongoloid, hydrocephalic, or can he be categorized as "brain-injured," which is more socially acceptable? The timing and circumstances under which the parents and family become aware or are made aware of their youngster's condition need also to be evaluated. Were they told at birth? What were they advised to do? Were they made to feel as though the child were contaminated?

A third group of factors relates to the nature of the family constellation itself. Included in this area would be the socioeconomic status of the family; its housing, health, and financial position; the size of the family, educational level, and material resources. Closely related to this are such factors which might be included under the category of the family's value system—its religious and cultural traditions, its style of life. Also, the personalities of the family members, the nature of their interpersonal relations, their perceptions of the child are of major significance in this regard. A host of questions stem from this consideration, and they need, all together, to be subject to systematic and individual study to obtain the required picture of the immediate social

environment in which the child functions. Finally, the family's reactions are conditioned by larger community attitudes toward their child and toward them as bearers of a retarded child.

Although major attention has been focused on the family for obvious reasons, what is required is a thorough analysis of the *whole* of the child's social experiences. In addition to the factors enumerated above, we need to know and to estimate the effects upon the child of his school experiences (or lack of them), his play experiences and friends, and the nature of his larger social contacts. What are the particular demands that living in his particular community makes of him? Is it rural or urban? Is the child isolated and abused or does he meet with some social acceptance? And, of course, what training and guidance have been provided? The answers to these questions would help further round out the picture.

It is still all too true, despite some hopeful beginnings, that the retarded individual is virtually a social isolate, is treated as an outcast or as a deviant, and is victimized by our current exaltation of the "body beautiful" and the quick mind. Having no stable and useful status in our larger society, he is at one and the same time cast in the role of the fool, the delinquent, and the insane. On the whole, he lives a life marked by frustration, social constriction, and with constant and all-too-obvious reminders of his failures as a human being. The retarded person is not, as we know, without feelings, sensitivities, and an awareness of how society values him. He reaches to these perceptions of the world in kind and mirrors quite accurately the role into which he has been cast. He is then further penalized and castigated by the very same value system and social institutions which have made him what he is.

These factors find their inevitable reflection in the kinds of behavioral problems and social difficulties so often observed, and which, by their very force, need to be eval-

uated to obtain a more complete understanding of the mentally retarded child as a human being. Thus we might say that successful work with the individual child is often predicated upon the ability of the social worker or the social agency to deal effectively with these social factors, in concert with other agencies and groups in the community.

In the course of the last two decades, the dimension and implication of problems of mental retardation have begun to be more clearly understood. The problems of the retarded have now come to be viewed as essentially similar to those of any other major chronic illness or disabling condition, and some important advances have been made in recent years in the development of methods of rehabilitation, education, and socialization. But despite the striking advance in knowledge and technique over the past two decades, a large gap still exists between what we know and how we have been able to help the parents of retarded children and the children themselves.

REJECTED BY WORKERS AND AGENCIES ALSO

From experiences in clinics for the retarded, special classes, and from data gathered elsewhere, parents of retarded children still find little understanding and receive little assistance from those very professional sources from whom help might be most fully expected: physicians and teachers, and the social workers and the social agencies. It is important to attempt to understand the factors that have brought about this widespread apprehension on the part of parents of the retarded to being rejected, misunderstood, or mistreated by community professionals—social workers and social agencies in particular. There is no reason to believe that members of the professional community do not share, in a greater or lesser degree, some of the vague popular superstition and revulsion that has been

traditionally associated with the retarded.

Also, for reasons too complex to explore more fully, there seems to have occurred a specific disavowal on the part of many community agencies concerned with child care and child guidance, as well as with family casework, of intent to serve the large group of the mentally retarded. Various rationalizations for this have been developed and some have indeed been elevated to the level of a kind of philosophy. In effect, this point of view holds that the retarded do not have the possibilities of making a "normal" adjustment and that agency services must, therefore, be limited to working with those for whom the prognosis is more favorable. It is open to question whether such a point of view squares away with traditional social work tenets of service to those in need.

Another factor of considerable importance in the lack of acceptance of responsibility for this field of work lies in the voluntary character and patterns of American communal health and welfare organizations. The limitations inherent in this system are that within it, co-ordinating and planning, as well as services offered, are essentially haphazard processes, coming about as they do largely through *voluntary* participation by separate agencies, each of which is under the direct guidance of individuals and/or groups that *may* have special interests. Under these circumstances, autonomous community agencies may or may not choose to serve or to exclude from service particular groups in the community. The co-ordinating bodies are generally not in an authoritative relationship with the independent agencies and can therefore seek the wide planning of services or the co-ordination of services only through methods of education and interpretation.

Another factor that should be singled out is that the development of services for the retarded has been brought about very largely in recent years through the activities of parent groups. Unquestionably, one of the problems of professional workers in

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relation to the mentally retarded is an unfamiliarity with patterns of working with parent-organized and other "self-help" groups. A certain skepticism seems to have grown up among many professionals around the potential of lay groups to afford or to develop any adequate service on the self-help pattern. In the case of the parent groups, parents retain a voice in the management and policy-making functions of the agencies, and it is this difference which seems to make the groups difficult for some professionals to accept. Yet, despite misunderstanding, some positive approaches have been worked out and some positive accomplishments have been registered under the mutual co-operation of parent groups and social agencies.

The need for continued efforts in the direction of attempting more fully to involve community agencies in the problems of the retarded seems most apparent. In the first place, there is an excellent body of experience and knowledge, service, and resources that has been developed and exists in the voluntary social agencies. The knowledge of human behavior and the reactions of family members to one another, the problems of obtaining more adequate resources from governmental and private agencies, dealing with the many emotional implications around questions of placement or institutionalization, the development of organized recreation through the application of group work techniques, the development of the social service aspect of the modern over-all rehabilitation clinic or center—all these have become or should be available to workers in the field of retardation, within the social agency competence of their community. Professional services in these fields may never have been extended to the retarded, but there is nothing within the philosophy of social work that justifies their exclusion.

As a further example, one of the most important problems encountered in work with the retarded has been the feelings of outrage and frustration engendered in par-

ents by professionals who have counseled them to place their children without true realization of what is involved in the parents' feelings on this score. In its work in child placement, especially foster care, over the last thirty years, social work has built up a sound body of knowledge and technique of the problems parents face in working through feelings around placement. There seems to be no reason why this considerable understanding and skill cannot and should not be brought to bear in those situations where the institutionalization of a child seems to be truly necessary and desirable. What is required is a process of mutual stimulation and service between those who serve the retarded and the traditional child placement field of social work—an exchange of techniques, information, and problems would do much to assist both groups.

Similarly in the field of family casework where the voluntary agencies have been developing considerable skill in understanding and in counseling with parents for whom their social situation has created difficult problems, the number of parents of the retarded who are being served by voluntary family casework agencies is still very small. Those who did succeed in being accepted by such agencies have found the skill of their staffs to be especially helpful. What is required, however, is a more intensive effort to increase the readiness of family agencies to take on more families of the retarded for help in working through their feelings and make appropriate plans—a greater educational effort is undoubtedly needed.

A PROFOUND CHALLENGE

The challenge that the retarded offer to the professional social worker is most profound both in terms of the complex community planning involved as well as in the rich possibilities offered in rendering needed individual services to the parents and siblings. If this challenge is to be met

and its possibilities grasped, it will mean that caseworkers, if not the field of social work itself, will have to explore carefully and systematically their skills and techniques in relation to the needs of this disabled group.

It will call for a distillation and some incorporation into practice of some of the content and knowledge of allied professions in the medical, psychological, and educational areas. It will mean, too, a critical reappraisal of some social agency structures and values (both apparent and hidden) that underlie both the social worker's approach to and his expectations of parents, and the testing of skills and services that will be more in keeping with the needs of the retarded and their families, and the advances made by some allied professions.

The social worker (in collaboration with social scientists and others) will also need to come to grips with those elements in our current social value system that place such heavy emphasis and high premium upon

intellectual prowess and the quick mind, and relegate those among us in our society who are incapable of this level of achievement to positions of lesser worth or status. Much needs to be learned about those factors that make for healthy social adaptations, and the workings of larger environmental forces that, in their own inexorable fashion, affect the stability of families and communities and influence the abilities of parents to adapt themselves successfully to the demands of the mentally retarded child.

Mental retardation is both a deeply personal problem to a parent of a child with this type of disability and a large and complex health and social problem to the whole community. The social worker's responsibilities include not only efforts designed to assist the individual child and his family, but also participation in broad community efforts directed toward the study and articulation of positive programs looking toward their social integration into the larger society.

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BY HANS D. FROELICH

The Forgotten Client

THE HOMEBOUND CLIENT is the forgotten client. A large group of people who often are in desperate need of counseling and other social services are practically excluded from them.¹ It is true that public assistance is extended when they are in serious financial straits; it is also true that some of them will profit from the 1956 amendments to the Social Security Act, which now provide benefits to some of the permanently disabled at the age of 50. Beyond these limited financial provisions, society has not overexerted itself in offering constructive help to the "shut-ins." Private efforts have remained isolated and limited in scope and efficiency. It was not before the 1954 amendments to the Vocational Rehabilitation Act that the federal government began to play an active role in social assistance to the homebound handicapped. A previous congressional investigation of aid granted to the physically handicapped yielded, in 1946, a report in which the homebound were only briefly mentioned; it stated that "the homebound have much to gain by the opportunity to acquire knowledge, philosophy, and artistic development, and are more dependent upon the pleasures of the mind than any other group." It therefore recommended that they "should have recourse to teachers and library service as widely as possible."² While

HANS D. FROELICH, J.U.D., is supervisor in the Family Division of the Brooklyn Bureau of Social Service, Casework Unit for the Handicapped. He is also unit field instructor at the Adelphi College School of Social Work, and lecturer at the Hunter College School of Social Work.

hardly anybody will want to quarrel with these findings and suggestions, it is undeniable that the homebound need much more than "the pleasures of the mind."

The Vocational Rehabilitation Act of 1954, Public Law 565, Section 7, charged the Secretary of Health, Education, and Welfare:

to make a thorough study of existing programs for teaching and training handicapped persons, commonly known as shut-ins, whose disabilities confine them to their homes or beds, for the purpose of ascertaining whether additional or supplementary programs or services are necessary, particularly in rural areas, in order to provide adequate general ameliorative, and vocational training for such handicapped persons.

The Secretary was to report on this study and to make recommendations within six months "after the date of enactment." The report was submitted to the House of Rep-

¹ The statement "The Physically Handicapped have been handicapped in the past as much by the attitude of society as by their physical limitations. . . ." is still true for the homebound. See Dean W. Roberts, Jayne Shover, and Eveline E. Jacobs, "The Physically Handicapped," in Russell H. Kurtz, ed., *Social Work Year Book 1957* (New York: National Association of Social Workers, 1957), p. 411.

The *Year Book* itself has little to say about the homebound in the article "Vocational Rehabilitation" by Virginia Denton, pp. 584-592.

² Report of the Committee on Labor, Subcommittee on Aid to the Physically Handicapped, 79th Congress, H. Report 2731 (October 10, 1946), pp. 12-13. Available from the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C.

representatives on February 3, 1955.³ Though it was prepared in collaboration with the Social Security Administration, the Office of Education, the Public Health Service, and the co-operation of numerous other public and private agencies, and though it contains a wealth of valuable information, it has not found the widespread attention of social workers which it deserves. Therefore, only limited progress has been made in efficient and comprehensive service to the homebound.

DEFINITION OF THE HOMEBOUND

The study early defines the homebound person as "one whose physical or mental condition prevents him from leaving his home regularly for education, training, rehabilitation services, employment or in pursuit of other activities."⁴ This excludes those whose illness or disability is of a temporary nature. For practical reasons, inmates of institutions were not included in the study either. The definition is interesting because it recognizes mental conditions as potential causes for confining a person to his home, while the title (though not the context) of Section 7 of Public Law 565 and the title on page V of the report (though neither the title page nor the "Letter of Submittal") mention only the "Homebound Physically Handicapped Individuals." There are, indeed, severe anxiety states, phobias, depressions, and other psychological conditions which make it impossible for the patient to leave his home. There is also mental retardation which may not prevent a person from doing simple manual work at home but may be too serious to allow him to travel unguided in a big city with complex traffic situations.

³ *Study of Programs for Homebound Handicapped Individuals*, by the Office of Vocational Rehabilitation, U. S. Department of Health, Education, and Welfare, 1955. Available from the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C.

⁴ *Ibid.*, p. 2.

VARIETY AND VOLUME OF PROBLEMS

A special situation exists for the blind. Usually they are favored in legislation and social services. Specialized public and private agencies, some of them endowed with ample means and splendid facilities, offer most valuable assistance. In a city like New York, some specialized private agencies are actually competing for clients and, through their very existence, encourage them to "shop around" or to play one agency against the other. Poor community organization has not yet allowed for a proper "division of labor" along functional or geographical lines and has not yet eliminated costly duplications and overlapping, which is not really helpful to the blind clients. The blind are privileged: e.g., in federal and many state income tax laws, or in such provisions as the permission to keep up to \$50 a month out of their earnings without deduction from public assistance allowances. The reason is the strong emotional appeal which blindness exerts upon legislators as well as the public. Certainly nobody begrudges them these small advantages. But anybody who works with the handicapped is well aware that other physical conditions make it much harder for the afflicted person to find or to hold jobs or to participate in "normal" recreational groups because they evoke an adverse emotional reaction in others, often bordering on revulsion. Such conditions as certain severe forms of cerebral palsy or epilepsy create a much more serious "social handicap" than blindness.

In spite of some privileges, the blind as such are usually not considered homebound, unless there is also another confining physical or mental condition. Many of them can learn to travel by cane technique or with the help of a seeing-eye dog, and they can often move around unaided in buildings that they know. Therefore, many of them can work outside of their homes.

Social agencies working with handicapped clients often receive applications for homework from people who are homebound not

The Forgotten Client

by physical or mental conditions, but by reason of family responsibilities. Such clients have to take care of relatives who, because of their age or their disabilities, cannot be left alone or may need physical attention and help at any time of the day. Numerous are the requests from mothers with babies or young children, from wives who must look after incapacitated husbands, or from women who have to give attention to invalid grown-up children or aged, helpless parents or other relatives. Their need is usually for small additional earnings, especially when family income is above Department of Welfare budgetary standards but so marginal that deprivations are inevitable and keenly felt. Such needs resulting from "social confinement" cannot be met by social agencies which offer homework to physically and mentally homebound clients. Referral to commercial sources of homework or to public and private employment agencies is indicated but is helpful only in a small number of cases.

Even if the blind and the socially confined clients are eliminated from the consideration, the number of homebound clients is large and constantly growing. As more people reach a greater age, handicapping conditions also increase. Many of these older people, though homebound, are anxious to keep themselves occupied and to increase their or their families' income. Exact data are not available, but the homebound population (excluding institutionalized persons) is estimated to number about one million persons.⁵ Only limited local studies are the basis of such estimates and of the surveys concerning the characteristics of the homebound (age, causes and severity of handicap, need for public assistance, and so forth).⁶

DIVERSITY OF SERVICES

Comprehensive services to the homebound would require (1) physical rehabilitation, especially in the functional activities of daily living (this encompasses skillful medical care in hospitals, often surgery, medical home care and nursing care when necessary, physical and occupational therapy, adequate aids and appliances such as prostheses, braces, and crutches); (2) educational and vocational services to enrich the life of the homebound and to enable them to work and to earn at home; (3) recreational services, wherever feasible; and (4) psychosocial services of a great variety. It is the last group of services which is so desperately needed and so poorly provided.

In addition to educational work for children, some progress has been made, at least in a few large cities, in vocational assistance by offering training and remunerative work to homebound clients. A small number of private agencies has always been pioneering in this field.⁷ Now public agencies, with the help of federal grants, also provide homework training to permanently homebound persons whose conditions will not be aggravated by working, will allow for the expectation of a reasonable period of productive activity, and are not contagious. The clients must have sufficient use of hands and arms, and at least normal dexterity and speed for employment as industrial homeworkers. They must also be able to work at least six hours a day and must be in need of income.⁸

Obviously, only a small number of all shut-in clients will meet these (necessarily) exacting standards. The government agencies must be selective for the reason that very little industrial homework is available for men. Even for women, it is highly sea-

⁵ *Ibid.*, pp. 4-9, p. 80. See also Lester Breslow, "Chronic Illness," in Russell H. Kurtz, ed., *Social Work Year Book 1957* (New York: National Association of Social Workers, 1957), p. 159.

⁶ *Study of Programs for Homebound Handicapped Individuals*, *op. cit.*, pp. 10-12.

⁷ There exists a National Committee On Sheltered Workshops and Homebound Programs, New York, N. Y.

⁸ Cf. "Rehabilitation Service for the Homebound," memorandum of the Division of Vocational Rehabilitation, New York State Education Department, New York, N. Y. (August 27, 1953).

sonal. Legal restrictions must be observed.⁹ Public assistance recipients whose earnings must be deducted from welfare allowances will often find that they are not better off financially than before, though they might gain satisfaction from keeping busy and owing at least part of their maintenance to their own efforts, in this way enhancing their self-respect and their status in their families. But what happens to those clients who are not eligible? Can their needs be ignored?

Even clients who can meet all the requirements for homework will often remain unsuccessful. The best technical training efforts may end in disappointment. The reasons are of an emotional nature.¹⁰ Did anybody strengthen and sustain the client's motivation toward homework? help him express frustration and relieve anxiety? understand and assist him in overcoming hesitation, ambivalence, and discouragement? sympathetically deal with his problems? or help relatives modify their deleterious attitudes toward him and his endeavors? Was anybody helpful in realistic planning and in straightening out practical difficulties? In short, did any qualified worker offer casework services?

PSYCHOSOCIAL SERVICES

We may visualize comprehensive rehabilitation in three broad categories: restoration or amelioration of physical (and mental) health, educational-vocational rehabilitation, and what we may call, for lack of a better term, human rehabilitation. Nearly always the client's total personality must be involved if rehabilitation is to be successful. His readiness, his courage, his confidence

and self-confidence, his will to participate, his initiative, his perseverance play a decisive role; so do the relationships to important people in his environment and their attitudes toward the handicapped person and his plans. To be born with a serious handicap and gradually to become aware of it and all its consequences, or to become handicapped in later life by an accident or serious illness is always a trauma and a severe threat. It may exclude many or all possibilities of a "normal" life, education, work, a career, vocational interests, a choice of social relationships, love and marriage; or it may at least narrow down such chances to a grievous degree. A tormenting body image may destroy any feeling of personal worth. In a society in which work imparts status and money has meaning far beyond its purchasing power, the ability to earn is of paramount importance. The many disappointments and rebuffs which become part of the handicapped person's life may create deep resentment, bitterness about having been singled out for a harsh fate and many deprivations, envy and hostility against others, discouragement and depression, human isolation, boredom, worries about loss of status and earning power, oppressive feelings of inadequacy and uselessness, growing anxiety about the future, and hopeless rebellion against physical, emotional, and financial dependency. Ambivalence about protective (often overprotective) attitudes, or exasperation about real or imaginary rejection or indifference may severely strain relationships with close relatives; guilt feelings may spring from this source and engender even deeper hostile feelings. Neurotic or psychotic tendencies may engulf the client. Obviously, such emotional reactions will be tremendously aggravated by long-term, perhaps lifelong, confinement to an apartment, a room, a wheelchair, or the bed. Friendly visitors, books, newspapers, radio, and television may still bring an echo or an image of the outside world, but this world itself is often out of reach.

⁹ See Report of the Committee on Labor, Subcommittee on Aid to the Physically Handicapped, *op. cit.*, Appendix IV, pp. 95-99.

See also Roberta Townsend, "Vermont Pilot Study on Industrial Homework," *New Outlook for the Blind*, Vol. 51, No. 7 (September 1957), pp. 309-315.

¹⁰ It has often been recognized that [in a large number of cases] "... the emotional problems are more disabling than the physical handicap." See Roberts et al., *op. cit.*, p. 418.

The Forgotten Client

Practical problems of vital importance often call for full discussion with an interested but "neutral" helper and for realistic action. Medical advice, help, and facilities may be needed but the homebound client may not know where to turn or he may consider his health condition "hopeless." A serious operation may have been suggested but the client may struggle with paralyzing fears that have to be worked through. Inadequate housing may create added hardships. The threatening question of institutionalization or removal to a nursing home, or the problem of separation from relatives and friends and from a long-cherished environment may cause the clients sleepless nights. These are only a few typical problems out of a limitless variety. A caseworker could offer considerable help with such problems that evoke deep anxieties.

Nor are the homebound handicapped clients the only sufferers. Their families are also deeply affected. They may be exposed not only to material deprivations caused by loss of income and heavy extra expenses for the care of an invalid, and to trying demands upon their physical strength and their time. They also experience serious emotional reactions of their own—anxieties, despair, ambivalence, resentment, rejection, hostility (often covered up by oversolicitousness), guilt feelings, uncertainties about the best way of dealing with the handicapped person and coping with changed patterns of living will haunt and distress them. They may be unable to understand the handicap, or they may deny its reality. The variety of interactions between the client's feelings and his family's emotional responses is unlimited, but they are always present and often create grinding hardships and unending difficulties. The problems are multiplied if there is more than one handicapped person in the family.

The constant presence of the invalid in the home sharpens friction between husband and wife, parents and children, and in-laws. The homebound person has no

opportunity to "blow off steam" outside the home, and he is a ready target for the pent-up feelings of his relatives. Each clash is more hurtful than in other families, since the shut-in person, unfortunately, has too much time to brood over each rash word or unkind attitude, and to magnify it in his futile "rumination." The relatives, however, also suffer; the feeling of having to carry a heavy burden hardens and with it hostility, guilt, or defensive indifference. In other situations, the constant need to be considerate, to repress impatience and irritation may cause severe, explosive tension.

ROLE OF THE CASEWORKER

In this area of "human rehabilitation," the caseworker can and should play a decisive role. His sympathetic understanding, calm acceptance, and realistic support could be a strengthening force of great value. Only a minority of clients will require psychotherapy—which is practically out of reach for most of the homebound persons anyway. Many clients and their families could benefit from skilled casework (including planning around tangible services), but often intensive counseling and long-term service will be necessary. The homebound client himself will require a number of home visits by a caseworker. Under present conditions, however, very few agencies are able to offer such continued contacts.¹¹ One visit and the necessary traveling often require half a day and are, therefore, costly. What agency has sufficient staff to make so much time available to a significant number of homebound clients for any length of time? Therefore, visits are made only on a very limited scale, sometimes only from crisis to crisis. Systematic, intensive work is often impossible for extended periods of time.

¹¹ About the acute shortage of qualified workers, see Roberts et al., *ibid.*, p. 418.

The "segmental approach," which leads to the organization of a separate agency for every major illness, worsens conditions and is another example of poor community planning. See Roberts et al., *ibid.*, p. 414.

The private agencies working with homebound clients have certainly given much thought to administrative planning, how to do the most and the best with the insufficient means at their command.¹² Careful selection of cases, organization of time, and geographical arrangements have been tried. Case aides and volunteers¹³ were introduced who, though they can be of valuable help, usually lack sufficient psychological understanding and skill to deal with complicated problems. Students worked with the homebound under conscientious supervision and such home visits proved an excellent learning experience for them—

¹² See the Summary from the Brooklyn Bureau of Social Service and Children's Aid Society, *Study of Programs for Homebound Handicapped Individuals*, op. cit., Appendix XI, pp. 118-120.

¹³ About the services of volunteers and volunteer bureaus see Robert F. Fenley, "Volunteers in Social Welfare," in Russell H. Kurtz, ed., *Social Work Year Book 1957* (New York: National Association of Social Workers, 1957), pp. 592-598.

but the clients did not always receive the skilled service which their situations required.

The answer lies, as in so many other areas of social work, in hiring skilled staff in adequate numbers. This leads, in the next steps, to the whole problem of recruiting and education, of the financial and societal situation of the profession, of the allotment of adequate governmental and private funds to the necessary expansion of social services. To legislators and the public at large, work with the handicapped has often been made "palatable" by the argument that recipients of public assistance can be transformed into taxpayers. Even though this point has great practical importance, social workers must emphasize the human values that are at stake. Much more help is needed for the forgotten clients, and sufficient money must be provided to meet a long-neglected civic responsibility. Within the limits of its material wealth, each society has the social services which it deserves.

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BY R. CLYDE WHITE

The New and the Old in Community Development

"COMMUNITY DEVELOPMENT" HAS caught the imagination of people around the world since the close of World War II. Up to fairly recent years it had only a vague, general meaning, but of late it has taken on the significance of a technical phrase of vast import. Is it a new concept new to the world? Does it look toward a new and more satisfying world? Or it is just an old phrase with a new but unspecified definition? I propose to examine critically the concept of community development as it is currently used and to review the evidence brought forward to give it meaning.

Efforts in various countries have been made for a number of years to stimulate people with a low standard of living to do something in their own self-interest, but a task was undertaken by the Economic and Social Council of the United Nations in 1951 which gave present impetus to talk and activity related to community development. Many things had got into print before the council published its report in January 1955, but this publication gave everybody some common vocabulary and ideas.¹ "Community development can be tentatively defined as a process designed to create conditions of economic and social progress for the whole community with its active participation and the fullest possible

reliance upon the community's initiative," said the council. "Community development implies the integration of two sets of forces making for human welfare, neither of which can do the job alone: (i) The opportunity and capacity for co-operation, self-help, ability to assimilate and adapt new ways of living that is at least latent in every human group; and (ii) The fund of techniques and tools in every social and economic field, drawn from world-wide experience and now in use or available to national governments and agencies."² This definition emphasizes community progress through self-help and the use of technical knowledge available.

The United States International Co-operation Administration through its Team I stated its concept in the following way: "... we believe that community development, as a series of formal programs in many parts of the world to which the United States Government is giving aid, is best thought of as an operation whereby the technical government services are channeled to and co-ordinated at the community level. Stimulation of community recognition of needs, and acceptance of the principle of self-help, is a basic part of this operation, but it does not, in the instances we have observed, in itself constitute community development. Rather, ... community development should be a method and an operation designed to complement the improvement of conditions from above by the improvement of conditions through the ini-

R. CLYDE WHITE, Ph.D., is professor of social work, Western Reserve University, Cleveland. This paper, in slightly different form, was originally presented at the University of Rangoon, Burma, January 1957. Mr. White has now returned to the U.S.A. after a year on the faculty of Social Administration, University of Thammasat, Bangkok, Thailand, as a Fulbright Lecturer.

¹ *Principles of Community Development*, United Nations Economic and Social Council, Document E/CN.5/303 (January 31, 1955).

² *Ibid.*, pp. 13-14.

tiative of the people themselves."³ This definition envisions community progress through self-help and aid by technical government services, but suggests that government may find one of its main tasks the stimulation of the recognition of needs by the people before they can take initiative.

One must conclude that, in the minds of people who write about community development, it is a loose concept into which one may put almost any idea which suits his fancy, and he may call almost any change in the direction of community improvement "community development." It is a movement of great inherent interest to social workers because social welfare is always one of the functions at the village level. In a large part of the world, it may result in the development of a new administrative structure for welfare services in which they will be related to other governmental functions in ways different from those found in most western countries.

HISTORICAL ANTECEDENTS

"Community" may be a small village, a district containing many villages, a city, a nation, or a cohesive group within one of these populations. The well-being of a number of people who inhabit an area in contiguous residential structures is in some measure determined by this fact of contiguity. If in addition to sharing occupancy of a geographical area they have strong common interests, the interdependence in well-being is greater. What is good for one or a few is likely to be good for all.

Among the most common of self-help communities are religious groups. Christian missions from St. Paul to the present have involved self-help on a broad scale in many instances. The efforts to change the theological opinions of people have been a small part of the stimulation to change. Emphasis has been upon interdependence with regard to ethnic interests, making a living,

promoting health, and other things. Technical help came from the outside but not from governments, and there was continuous effort on the part of the missionaries to induce the people to improve their social and physical ways of living. Some famous "communities" in the United States have been the Amish, the Hutterites, and the Mormons. Religion provided the emotional cohesion, but all of them were and are concerned with improving the material, health, and often educational standards of living. They expected to achieve these ends mainly through self-help on a large scale but with little technical help from outside, except that most of them take advantage of mechanical inventions by whomever made.

Some very good illustrations of self-help with outside assistance, technical and moral, are provided by the social settlements which were in all great cities. Originally a few devoted persons, for religious as well as social motives, moved into the slums to live with people who had a very low level of economic existence and where ignorance of health and the world were great. They identified with the people of the neighborhood: here seems to have been community development at the "neighborhood level" in the big city. Such foundations or community centers appeared nearly a hundred years ago in London, Chicago, Boston, New York, and other cities. Many of these original settlements are still operating—at least enough to indicate that a community development project may be relatively permanent and may serve succeeding generations by helping individuals and families to better material standards of living, by bringing health services to the neighborhood and teaching the people how to use them, and by providing a great variety of adult (or informal) education classes for men and women and many activities for children in their out-of-school hours.

ILLUSTRATIVE PROGRAMS

One important difference between community development now and in the distant

³ *Community Development Programs in India, Pakistan, and the Philippines, Team I* (Washington, D. C.: USICA, October 5, 1955), p. 9.

Community Development

past is that in many nations it tends to be a national program and the emphasis is largely on the village. This is a quantitative difference, but it is convincing evidence that the undirected experiments in self-help have been successful. Community development has become a national program in India, the Philippines, Egypt, Iran, and Thailand.

The Indian plan was started in October 1952 to bring about an "effective development of her natural and human resources." About 80 percent of the population of India lives in 558,000 villages, few of which have the characteristic marks of urban communities. The object of the plan is to improve agriculture, drinking water, irrigation water, village roads connecting main highways, education, and health and sanitation. It further intends to stimulate cottage industries, land reform, rural co-operatives, and credit. Community development is established by law as a major function of the national government. At the top level the Planning Commission, of which the prime minister is chairman, has general responsibility. A Community Projects Administration has been set up to co-ordinate the activities of the various central ministries concerned with the program. Each state at the next level below has a Development Committee, headed by the chief minister and composed of all other ministers. The committee has an executive known as a "development commissioner." Below the state level is the district. This in turn is divided into "project areas" consisting of about 300 villages each. The head of each project is known as a "project executive officer." The project is broken down into blocks of about 100 villages each, headed by a block development officer. Below the block is the village. At the village level is a multi-purpose "village level worker" who stimulates and assists the villagers to think of their problems, plan through group action to aid themselves and to use the technical assistance of specialists from the block and district offices. Communication is both

down and up the hierarchy.⁴ Village councils are organized.

Community development in the Philippines is not unified, as in India, but is characterized by the independent efforts of each department of the national government to promote "community development" with respect to its own function. The departments listed as active are Education, Agricultural Extension, Agricultural Credit and Co-operative Financing, Health, Public Works and Communication, National Defense, Social Welfare Administration, and Resettlement and Rehabilitation Administration. The Departments of Education and Social Welfare Administration have undertaken at the village level to co-ordinate some of the functions of other departments. The late President Magsaysay had created a Community Development Planning Council composed of the chairman and secretary of the National Economic Council and several secretaries of departments, but at the end of 1955 it had not been very active. This would be a step toward co-ordination at the top, similar to the Indian plan.

Egypt presents great organizational difficulties for any attempt to improve the level of living of the rural population. It gained its independence from Great Britain only a few years ago, and it has had two *coups d'état* since then; more recently it has been invaded by Britain, France, and Israel. The country has 16 provinces, 116 counties, and about 4,200 villages. Government is highly centralized in the Revolutionary Command Council. Governors of provinces are appointed by the central government. Counties and villages have had little experience in self-government, and the villagers are skeptical of the motives of any official who appears to want to do something for or with them. Activities are going on in many places to improve conditions of living: agriculture, utilization of natural

⁴ *Community Development Programs in India, Pakistan, and the Philippines, Team III* (Washington, D. C.: USICA, December 1955), pp. 12-15.

resources, industry, transportation and communication, public administration, health, education, and housing. A country-wide agricultural extension service has been planned. A number of health projects have been started. The Qalyub Province project at the edge of Cairo with 43 villages and a quarter-million people is a demonstration and training center for community development. It was chosen because it has both rural and urban problems. This project gets much foreign aid. It is relatively unified, with emphasis placed upon participation by villagers. It illustrates community development problems, organization, and methods in an area which is undergoing industrialization and urbanization. Qalyub is a large-scale example of community development which is both rural and urban.

In Iran, three more or less distinct programs for community development have been in operation: (1) The Development Block Program on the Shah's lands is related to his redistribution of the large royal estates; (2) a program of so-called "fundamental education" operating in 44 villages through the educational system; and (3) the Village Council Program aimed at improving the standard and level of living of the farmers. Of the three programs, the latter is by far the most important because of its extent and promise. At the national level is the High Council for Rural Development of which the Minister of the Interior is chairman. Other members are drawn from the ministries considered related to the community development program. The council has lacked sufficient funds, but another equally serious difficulty has been the departmental rivalries. The governmental structure vertically in Iran is similar to that in other countries: national, province, district, county, township, and village levels. Each of these levels has some sort of a council, but only at the village level is the council in any sense representative of the community. About 80 percent of the people are illiterate. Of the 40,000 villages in Iran more than 90 percent are owned by land-

lords. The problem of personnel training is of primary importance. Unassigned persons in the civil services or those lent by other departments, regardless of their training in matters related to community development, make up a heterogeneous cadre which lacked the skill to work together and lacked common knowledge either of program or objectives. The result has been personnel which is overspecialized or generally incompetent for the job to be done. Little attention has been given in training to subject matter dealing with motivation, community organization, and group participation. This situation may be on the way to improvement. A young director trained in community organization in the United States is working at the job with enthusiasm.

The first move toward community development in Thailand began simultaneously with a center for training village level workers.⁵ The Ministry of Education took the initiative in 1954, and this particular effort remains a project of this ministry. It is in its fourth year. Each year 60 young teachers from 10 provinces are chosen for their interest and seeming aptitude for community development to attend at the expense of the ministry the Thailand-Unesco Fundamental Education Centre for two years. Then they return to their provinces to work under the Ministry of Education in a single district (*amphur*). Meantime, the national cabinet created a Community Development Board of which the Prime Minister, as in India, has been chairman. The Director-General of Public Welfare is the secretary and has been given the task of drawing up plans for community development in each province and getting them into operation within five years. The time is much too short, because personnel cannot be trained so rapidly, even if funds were available, but work is going on. Presumably the program of the Ministry of Education will be absorbed by the Community Development Board which represents all relevant ministries.

⁵ See page 55.

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Experience in these five countries seems to indicate that community development shows promise of success where (1) it has been organized as a separate function of government from the highest to the lowest levels, (2) personnel has the appropriate training in general and special knowledge and in social skills and (3) villagers can and do participate in making and carrying out local programs.

RURAL AND URBAN DIFFERENCES

The five nations used as illustrations have with one exception been concerned exclusively with rural communities. Only Egypt selected a pilot area which included part of a great city, but the matter is being considered in Thailand. Is the theory of community development inapplicable to urban areas or to economically highly developed nations? Apparently a project or a process can be called community development, whether it is done by a national agency created for the purpose, by a ministry of education, or by a ministry of agriculture.

If a program to be called community development does not have to be a general program in a community, then it can relate to some special need, such as illiteracy, farm production, home-making, relatively low average income in a particular community, health, or family breakdown. The program then would be selective with respect to the most urgent problems. They might include the whole range of social life or might include a single aspect but utilize personal and institutional relationships of various kinds to attack the special problem. This was the plan of the Ministry of Education in Thailand. Specialists would then vary according to the range of community development problems presented, and the activities at the local level would vary from one village to another. This was becoming increasingly clear in Qalyub at the time I visited it last July.

The common human problems with which community development deals are

(1) health, including health education, medical care, and preventive services; (2) home economics, including preparation and use of food, household management, interior decoration, and family life; (3) education, including primary and secondary schools, subject-matter classes for adults, informal education for adults, and specialized training of many kinds; (4) production, including agriculture, industry, and the activities related to distribution; (5) leisure-time activities; and (6) social welfare, including maintenance-of-income programs, individual and family counseling, treatment of delinquency, group therapy. Only in the Thailand-Unesco Fundamental Education Centre at Ubol have I seen substantially all these interests taken into account. Often, a very few are actively in the program, because some of them are not even recognized by villagers as problems and in fact may not be problems. So when it is asserted that community development is concerned with the all-round improvement of a village or other community, what is meant is concern with all-round improvement with respect to recognized problems and needs.

Local leaders, if they are going to give energetic direction to community development, are persons with relatively high prestige. The aim in India and the Philippines and other places has been to have a local council. If the village is large, there may be committees or subcouncils for special functions. The members, if they are going to lead, are persons who have prestige with respect to the total program objectives or with respect to particular parts of it. In rural communities the leaders will be the large farmer, the priest, the teacher, and the public official—somewhat in that order of descending prestige. The urban community is likely to have influential leaders from the following groups: persons with royal or noble titles, if any; members of the major professions; the heads of large business enterprises; high government officials, civil and military; and wives of such im-

portant persons, with or without high achievements of their own. Such people are volunteer leaders. They may do much alone, but they are likely to do much more when supported by competent employed personnel.⁶

There will be some major differences in foci of interest in rural and urban communities. Characteristically the interests of the rural community in an underdeveloped country will be centered upon production or health first. Education will be important, and so will home economics. They are likely to be less concerned with conventional welfare problems and programs: the family system is stronger, and mutual aid is traditional. In the urban center, production and education are on such a large scale that they are relatively self-propelling. If private enterprise prevails, the massed force of individual interest results in maintenance, improvements, and expansion in business. On the other hand, the lame, the weak, the very young, the old, the widowed, the fatherless, and the neglected tend to drop through the holes in the relatively impersonal machinery of urban life, and social welfare becomes a major interest. A community development team in a large city of an industrial nation would have little use for a village industry specialist or an agricultural expert, but they could use an occupational guidance person, a visiting nurse, and a social group worker.

The so-called underdeveloped countries are underdeveloped with respect to economic activity, especially production and utilization of natural resources. Most of their population live in rural areas and relatively isolated from urban centers of change. The big city in such a country is all the more bewildering, because it contrasts sharply in many ways with the ancient

order and quiet of the village. It is, therefore, clear why present-day enthusiasm for community development should be greatest in nations with predominantly rural populations, and, if the standard of living is low and the land overcrowded, the national leaders find all the more reason to try out this device.

In order to show further that community development is something which is found in industrial nations, it is appropriate here to mention the "area councils" found in many cities in the United States and Canada. These councils are composed mainly of persons who live in the areas and who employ a secretary or director and such other personnel as may be indicated. The director is usually someone with graduate training in community organization or social group work. Occasionally a teacher with interest in adult education is brought in for director. These councils have fairly definite geographical boundaries to their areas, which are determined by certain common characteristics of the population. That is, they bear some resemblance to a rural community, but they are found surrounded by many other densely populated areas. Improvement of welfare service is one of their activities usually, but they gain most enthusiasm for doing something about delinquency, housing, zoning ordinances, gambling, prostitution, or cleaner neighborhoods. Their object is to make their own neighborhoods better places in which to live and rear children. This seems to belong to the order of activity known as community development in many countries.

LEVELS OF PERSONNEL TRAINING

Community development will attain its promise only with good organization and suitable, properly trained personnel. I have discussed the questions about organization in connection with the outline of plans in India, the Philippines, Egypt, Iran, and Thailand. It was shown that best results seem most likely when the function of com-

⁶ The United Nations Economic and Social Council considers community and area councils in many countries to be part of the machinery of community development. Canada and the United States are mentioned. See *Principles of Community Development*, *op. cit.*, par. 56-58.

Community Development

munity development has a distinctive organization from highest to lowest level parallel to that of other functions of government. At each of these levels co-ordinating administrators and technical personnel with appropriate education and experience are indispensable to the success of the enterprise. At each of the levels, following the Indian structure, some official has to be responsible for co-ordinating the parts of the program and the activities of the technical specialists, and the co-ordinating official has to reach upward and downward in the administrative hierarchy. How can suitable personnel be obtained? What professional disciplines are required?

Much has been learned by trial and error about the kinds of personnel which are most satisfactory in community development, but much remains to be learned. One of the most interesting and carefully planned experiments in training personnel for particular levels is the Thailand-Unesco Fundamental Education Centre at Ubol. It began operation in 1954 to train village level workers.

Tufec, as the project is called, is a school which has laboratory facilities in the villages. Students are public school teachers who have been chosen from a list of applicants and assigned by the Ministry of Education. They have had three years of teaching experience or more, and the average age is 22 years. Six are chosen each year from some province in each of the nine regions of Thailand plus the Ubol laboratory area. They come for a two-year course, after which they go back to their provinces to work as teams of six out of the *amphur* office but at the village level. The curriculum is built around seven fields of work: agriculture, education, home-making, village industry, health, social welfare, and the production of instructional materials. During the first year, all students gain some knowledge of all fields and make observation trips regularly to selected villages. In the second year, each student in the team selects one of the fields for some degree of specializa-

tion and spends a large part of his time helping to do a survey of the village, getting acquainted with the needs of the people as they see them, and starting with them to organize for improving the level of living in varied fields. There is a Tufec village center in each village where the team lives, when in the field during the second year. Students are divided about equally between men and women.

No attempt has yet been made to train people for district or province community development administrators. Nor has training for certain specialists for the province level been undertaken. However, as at Qalyub Project, it is recognized by officials at Tufec and by the Dean of Social Administration of Thammasat University that such trained specialists are necessary and should probably have at least a year of graduate training. The Division of Community Development, U. S. International Co-operation Administration, is now providing some money to send graduate students from some countries to study one or two years in the United States. Some are in schools of social work.

Two kinds of personnel are required: (1) technical specialists, such as agricultural extension workers, home economists, public health nurses, social workers, and specialists in adult education; and (2) community development administrators with ability and responsibility for co-ordinating staff and program at each level. Obviously, the primary training of the specialists should be obtained in agricultural colleges, liberal arts colleges, medical schools, schools of education, schools of nursing, and schools of social work. But where do these specialists and the administrators get their training in human behavior, group dynamics, and the process of community organization? This training includes acquisition of both knowledge and skills in working with individuals and groups.

The Tufec-trained young people are village level workers. Occasionally one of them may show administrative ability and

become an *amphur* (district) co-ordinator or director, and he might climb the administrative ladder in the course of time. But in the United States we have observed that more advanced training is needed for broad-gauged administrators. Also we have learned that a specialist is often only a specialist unless he has somehow had university and/or apprentice training in fields of knowledge and skills involved in human relationships. During the last thirty-five years the graduate schools of social work in the United States have learned to give students a body of knowledge and of skills in human relationships which I believe is unequalled by any other kind of professional education. The pedagogical methods used for training leadership for groups and communities need to be studied much more by the people responsible for organizing and administering community development programs. Furthermore, the directors of these programs should draw some of the group workers and community organizers trained in these schools into the community development programs at strategic points to see what contributions they can in fact make.

It may be that all community development professional personnel, whether specialists or general administrators, should have at least a semester of special training in a curriculum like that of the schools of social work in Canada and the United States. Programs will use social workers as specialists, obviously, but the informal teaching, audio-visual instruction, group discussion, and introduction to democratic participation in community life are integral to community development, not only at the village level but at all levels, and they are the stock-in-trade of the social group worker both as a group worker and as a community organizer. A plan for one graduate year in a "community development" curriculum in the University of Thammasat has been approved by the Rector and by the National Economic Council. It is proposed that the program should be financed jointly by

Thailand and the United States for three years and then rapidly taken over by Thailand. The students would probably be in government service already and would be trained for positions at the provincial level.

SUMMARY

I have tried to examine the concept of community development and some of its historical antecedents. Briefly it can be said that (1) neither the concept nor the methods of present-day community development are new, but the national scope which it now has in some countries is new. (2) Five illustrative national programs described show that methods are various and that varying degrees of success found seem to be closely related to a structure, clearly conceived, which is independent of other governmental agencies and extends from the highest level of government to the lowest. (3) Community development is having its largest operations now in countries which are primarily rural, but analysis shows that it can be and has been used in large cities. (4) Although it appears to be adapted especially to so-called underdeveloped nations, it has important uses in highly developed nations, but the programs would differ because of the degree of economic development (*e.g.*, agricultural and home economics extension and the urban area councils in the United States). (5) Efforts to identify the kinds of personnel needed and to devise training programs for the purpose have been limited so far to personnel who would operate at the lower levels, but unless able, properly trained people are available for the upper levels which require greater ability, the program will disappear for lack of direction. (6) While many of the areas of knowledge and skills needed in community development have been identified, there is little evidence that leaders have made much use of the knowledge and skill in group and community leadership which schools of social work have learned to communicate effectively to their students.

BY JOHN C. KIDNEIGH AND HORACE W. LUNDBERG

Are Social Work Students Different?

THE ACCOMPLISHMENTS OF any profession and the recognition it attains are directly and vitally affected by the number and competency of its individual members. The adequacy of the supply of incoming new members of the profession and the quality of their endowments deserve careful study if recruitment to the profession is to be aided. Numerous questions concerning supply as well as questions concerning the endowments or competencies could be posed for study. Studies of this kind should be conducted in and for the profession of social work.

As they relate to social work, certain questions seemed to us to be of such importance as to deserve high priority in any series of studies. Some of these questions could be phrased as follows: Is social work drawing its recruits from a "common pool" from which certain other professions also draw their recruits—hence, is social work in competition with these other professions for recruits? Is there relative homogeneity among social work students along certain measurable dimensions of personal and social characteristics and, if so, do social work students differ from students in other professions in these characteristics? Is there a relatively untapped source of recruits that can be identified, toward which recruitment efforts can then be directed? These and similar questions prompted the design and execution of the study reported briefly in this article.

JOHN C. KIDNEIGH, M.A., is director, School of Social Work, University of Minnesota. HORACE W. LUNDBERG, Ph.D., is associate professor of social work, University of Utah.

Another set of self-evident factors or problems indicates the need for this kind of research. Acute personnel shortages in the professions concerned with health and welfare cry for a solution. The professions in the social fields seem to be in competition for capable manpower with high status professions, such as medicine, and with technological fields. Apparently, a service motivation is an important concomitant—if not a deciding factor—in vocational choice when a given individual chooses a social service profession such as social work, education, or public health nursing.

Social work has continued to value and emphasize capability and motivation in selecting students for entry into professional education—and this in the face of a relatively smaller volume of persons in the population of the age range available for recruitment. Maintaining selection standards may thus accentuate the shortage problem. At the same time, employing agencies and the professional schools themselves may relax qualitative standards in the face of stringent manpower shortages.

Hence, in the face of the downward trend in students graduating from accredited schools since 1950-51,¹ what appears to be needed is an untapped manpower resource (which would involve a sweeping social policy giving opportunity for those capable of successful college work an opportunity to get a college education—all such do not now have that opportunity), and a more precise description and measurement of those personal and motivational factors which we recognize as essential for success

¹ Nathan E. Cohen, "A Changing Profession in a Changing World," *Social Work*, Vol. 1, No. 4 (October 1956).

in social work. Intensive recruitment and selection could be improved and made more efficient thereby.

Social work has responded to the problem of personnel shortages in a variety of ways, but this is not the place to summarize the modes of action adopted by organizations and agencies in the field. We do recognize the valuable intensive recruitment efforts, the financial support for education, the fellowships for graduate professional study, the vigorous activity of the Council on Social Work Education (involving accreditation, workshops on admissions, publications, and co-ordination of recruitment), the activity of the National Association of Social Workers, and the research in various schools of social work on recruitment and selection² as all contributing to the search for a solution to the manpower problem in the field of social work.

The School of Social Work at the University of Minnesota has been active in research directed to certain dimensions of the problem of recruitment and selection for social work.³ The research briefly reported below is a continuation of its interest in this general area and, like the vocational interest pattern study, was financed in part by the Louis W. and Maude Hill Family Foundation of St. Paul, Minnesota.⁴

CHARACTERISTICS OF STUDENTS

This study was limited to an exploration of certain characteristics of students entering

training in social work and six other professions. Through measures, some of which were prestandardized, scores and profiles of certain characteristics were secured and an analysis of significance of difference between the social work students and the students in the other six professions was made to determine which of the characteristics being measured distinguish social work students. Secondarily, an analysis between experienced and inexperienced social work students was made. The characteristics included social attitudes, the nature of the students' social origin, intellectual capacities, academic interests, and certain circumstances surrounding choice of profession.

The study was a comparative and descriptive study of two groups of students: (1) entering graduate social work students, and (2) students in six other professions at a comparable collegiate level. The null hypothesis was employed to facilitate the use of statistical techniques as a safeguard against random or chance error.

The basic technique for measurement of student characteristics was the questionnaire. In obtaining data both individual and group administration was utilized. Two standardized measures were incorporated in the questionnaire. One, the College Vocabulary Test, was used to measure verbal intelligence.⁵ The Authoritarian Personality Social Attitudes Battery—Levinson's selection and/or modification of items originally produced by the Berkeley group—was employed to measure opinion and attitude, and the "kind of personality organization" from which opinion and attitude spring.⁶ A well-known technique, the Hollingshead Two-Factor Index of Social Position, was employed to compute social class from information about the educational and vocational attainment of the respondent.

² One illustration of this type of research is Sydney Berengarten, "A Pilot Study: Criteria in Selection for Social Work" in *Social Work as Human Relations* (New York: Columbia University Press, 1949).

³ A number of master's group research projects as well as several doctoral dissertations have been focused upon one or more aspects of the problem. For a published report of one of these studies see Robert L. McCornack and John C. Kidneigh, "The Vocational Interest Patterns of Social Workers," *Social Work Journal*, Vol. 35, No. 4 (October 1954), pp. 161-163.

⁴ Horace W. Lundberg, *Some Distinctive Characteristics of Students Entering Graduate Social Work Education*. Unpublished doctoral dissertation, University of Minnesota, 1957.

⁵ Harrison G. Gough and Harold Sampson, *The College Vocabulary Test* (Berkeley: University of California, 1954).

⁶ T. W. Adorno, Else Frendel-Brunswick, Daniel J. Levinson, and Nevitt Sanford, *The Authoritarian Personality* (New York: Harper & Brothers, 1950).

Are Social Work Students Different?

ents' fathers.⁷ An additional 20 items were included in the questionnaire to obtain information about the nature of the students' social origin and circumstances surrounding their choices of a profession.

The experimental sample contained 80 students, all the nonforeign students entering social work in the 1956-57 academic year at the universities of Iowa, Kansas, Minnesota, and Nebraska.⁸ The control sample contained 180 students enrolled in their fifth college or professional year at the University of Minnesota. It consisted of 6 randomly selected subsamples of 30 each. These were students entering education, engineering, law, library science, nursing, and psychology.

We omit from this presentation a full description of the technical and statistical methods employed in the analysis of the data and report here only a limited amount of the findings. The findings that are reported were selected because they bear upon the questions posed at the outset.

DRAWING FROM A COMMON POOL

Is social work drawing its recruits from a "common pool" from which certain other professions draw their recruits? is a question that can be answered in part on the basis of our findings. In certain dimensions, and for some of the characteristics studied, social work students are not significantly different from the students in the other professions. Hence, there seems to be some evidence to support the notion that the professions studied are drawing from a "common pool."

This generalization seems stronger in connection with social work, education, nursing, and psychology than with all the seven professional groups. In other dimensions and characteristics, however, social work students differ significantly from the stu-

dents in the other professions. Thus there is evidence to cause us to question whether social work recruits and recruits from other professions, particularly engineering and law, really constitute a "common pool."

The social work students in this study were found to have similar academic interests with students in education, nursing, and psychology. Their salary expectations paralleled those of students in nursing, library science, and education. In verbal intellectual abilities they did not differ significantly from the combined control group.

In their cultural and social origin, social work students were similar to the students in the other six professions in nationality, race, and social class. Interestingly, the social work students in this study most frequently came from social class IV, as identified by Hollingshead's index. Class IV on this index is chiefly clerical and salesworkers, technicians, and owners of small businesses. This finding appears to differ from the finding of Polansky's research on the social class of social workers in Detroit, Michigan.⁹ It would seem that the finding of a greater frequency of class IV individuals, suggests a wider field for social work recruiting. Individuals from this class are not now believed to be proportionally represented in higher and professional education programs. In other words, the individuals originating in professional and white-collared classes, found to be most common among the Detroit social workers, more frequently secure advanced education.

Social work students in the current study were found to have made their choice of a profession at a later period in life than had the students in the other six professions. They also felt less parental support in their choice—at least from the mothers. A practical problem is suggested by this finding—where to place future recruiting emphasis. Would greater effort at the "during

⁷ A. B. Hollingshead, R. Ellis, and E. Kirby, "Social Mobility and Mental Illness," *American Sociological Review*, Vol. 19, No. 4 (October 1954), pp. 579-582.

⁸ We wish to express our thanks to the schools that so generously co-operated with us in this study.

⁹ Norman Polansky, William Bowen, Lucille Gordon, and Conrad Nathan, "Social Workers in Society: Results of a Sampling Study," *Social Work Journal*, Vol. 34, No. 2 (April 1953), pp. 74-80.

college" period produce better results and reduce, comparatively, the larger "after college" decision rate among social workers? Is social work losing valuable recruits because of this characteristic "late decision" phenomenon?

SOCIAL ATTITUDES

Perhaps the most important conclusions supported by this research derive from the data on social attitudes. The value of this material accrues from the central importance placed on student attitudes and their derivative motivations in the social work profession. (In this instance added weight is given the conclusions by the objective means used in obtaining the data.) The social work students were found to be more liberal (lower scores) in their view than the control group on the following points:

- ✓ 1. Anti-democratic tendencies: failure to allow freedom to others to control their own lives.
- ✓ 2. Ethnocentrism: an acceptance of the culturally "alike" and rejection of the "unlike."
- ✓ 3. Political-economic conservatism: "things as they are" or support of the *status quo* in contrast to "liberal" tendencies, where liberalism is considered to be, at least, the ability to actively criticize existing authority.
- ✓ 4. Interpretation of traditional family ideology: stress on "masculinity" of the male role and "femininity" of the female role, old-fashioned child rearing and strong moral pressure on sex and aggression.¹⁰

It was assumed the respondents were not only recording a view about a topic, in responding to the T.A.P. Social Attitude Scales, but something of their life philosophy across an "authoritarian-equalitarian" dimension; hence, the social work students' scoring on the above scales has been considered to correlate with qualities valued

by social work educators and the social work profession. These qualities (qualities having an inferred relationship to a liberal score on the T.A.P. Battery) would include non-judgmental attitudes toward a client, meeting dependency without control, warm and understanding acceptance, and the lack of personal bias in the social worker.

It would appear, then, that by self-selection, school selection, or a combination of these with other variables, the social work student group in this study demonstrated social attitudes that separated them significantly from students in the other six professions in the four areas of social attitude discussed above. This finding is encouraging as it parallels the intent or design of the social work recruiting and selection program. It also seems to indicate that we cannot accept the "common pool" concept mentioned at the outset.

While we found some variability among the social work students in each of the characteristics studied, it can be stated that there is relative homogeneity in the total group. One analysis was directed to the question *Is there any significant difference between social work students with prior experience in the field and social work students without prior experience in the field?* No statistically significant difference was discovered, by any of the measures used, between these two subgroups of social work students.¹¹ The relative homogeneity of the social work group appearing concomitantly with findings of significant differences between the social work group and the "other professions" group leads one to conclude that the "common pool" concept in recruitment is too vague. Motivation, self-selection, and actual admission to professional education for social work appears to be associated with a constellation of already possessed or pre-conditioned social attitudes. Therefore, the second question posed, *Is there relative ho-*

¹⁰ Statistical significance ($P .001$) was found on these items by both parametric and nonparametric tests.

¹¹ Parenthetically, we could say that the validity of single programming of social work students as presently practiced in schools of social work is at least partially sustained by this finding.

Are Social Work Students Different?

homogeneity among social work students? can be answered in the affirmative.

This study does not provide a definitive answer to the question concerning the identification of an untapped source of recruitment for social work. The fact that the fathers and families of social work students are frequently in the occupational class IV, according to Hollingshead index, suggests that recruitment efforts directed at young people from families in that class should be considered. Because young people from families in that class less frequently seek and attain a college education, a more sweeping and fundamental social effort to get a higher proportion of them into college may have to be set in motion before social work could benefit to a desirable maximum degree.

TENTATIVE FINDINGS

Certain generalizations with concomitant implications or recommendations are tentatively proffered on the basis of the findings of our study plus the concurring evidence found in other research and literature in the field.

1. Social attitudes, as measured by the Authoritarian Personality scales, of social work students differ significantly from the students of the "other six professions" group. Further research is indicated from which vocational counseling and admission selection tests could be designed for use. Particularly a study of the high scorers (meaning that there is greater conservatism and traditionalism) should be undertaken because we surmise that such individuals may possess personality characteristics or social attitudes which would limit their usefulness or adaptation to social work. We do not know, however, how much undesirable attitudes can be modified by professional education.

2. The development and use of objective tests designed to measure crucial aptitudes for social work, including attitudes, would improve present selection and admission

practices.¹² Other admissions methods and materials, such as the biography, the interview, and the transcript of credits, should not be displaced, but objective testing promises to give added precision in selecting and predicting successful achievement in and adaptation to the field.

3. Appropriate efforts in recruitment should be made to increase the proportion of qualified students who originate in the lower socioeconomic classes. This seems to be a compatible and relatively untapped personnel resource. The efforts should include financial assistance involving scholarships and fellowships. Psychological as well as economic barriers should be removed as far as possible so as to increase the number of such students that continue their education through college and professional school. All teachers, counselors, and school public relations officials, as well as social workers, have a part to play in reducing those barriers.

4. Schools of social work should not hesitate to accept qualified experienced students lacking graduate professional social work training. Such students are likely to be equally capable of using and benefiting from the same professional training as inexperienced social work students.

5. Because of the frequency of answers to the "political-economic conservatism" items which indicated that the students in all the professional fields seem to favor a quite limited role for government in social welfare, it seems to us that a major problem in general education exists. More information, a clearer definition of the role of government in human welfare, and explication of the present-day philosophy of service through government as an instrumentality should more thoroughly permeate general and professional education.

¹² One such test is being developed at the University of Minnesota, School of Social Work. See Anne W. Oren, *The Construction of An Instrument for the Measurement of Social Workers' Attitudes Associated with Aptitude for Interpersonal Relationships*. Unpublished doctoral dissertation, 1957.

BY HENRY S. MAAS

Use of Behavioral Sciences in Social Work Education

BASIC PROBLEMS in the use of the behavioral sciences in social work education may be categorized as at least four in number. They are the problems of segments, identity, selection, and reintegration for use. These four classifications provide boundaries and a sequence for this paper. Under the heading of "segments," I shall refer to the compartmentalization of both graduate social work education and of the behavioral sciences, situations which complicate efforts to use the latter in the former. The term "identity" introduces a proposal as to what the integrated pieces of graduate social work education are, in behavioral science terms. The section on "selection" brings us to illustrative questions to guide our sorties into the literature of the behavioral sciences. The fourth and final category, "reintegration for use," is, I believe, self-explanatory.

SEGMENTS

The problem of segments, or compartments, refers to the current structure not only of knowledge in the behavioral sciences but also of social work education itself. One cannot consider problems concerning the articulation of knowledge in the behavioral

sciences and of the content of social work education without first recognizing that internal divisions and divisiveness currently characterize both fields.

Social work educators, concerned ultimately with the modification of conditions under which man's life becomes stressful, must search widely for basic knowledge about such conditions. The compartments of the biological, psychological, and social sciences are multiple. Arguments as to first cause among specialists in soma, in psyche, and in social systems mystify the social worker who daily sees clients with bodies, with memories and motives, responding and adding to a society's cultural, economic, and political pressures, past and present.

It is the nature of all sciences to delimit fields for study. Mammoth accretions of highly specialized knowledge today perpetuate the scholar's separations of the cell, the self, and social organization. With hindsight, some of us wish the sciences of man had evolved and been divided in other ways. A single science addressed to questions, for example, of how the dependent infant becomes the venerated or rejected aged member of a community would never have provided us with formulations on groupless persons or personless groups. Be that as it may, professional people in fields of action like social work need integrated (or interdisciplinary) knowledge to direct their skills in dealing with man under stress. We should, therefore, bid Godspeed to the Roy

HENRY S. MAAS, Ph.D., is professor of social welfare at the School of Social Welfare, University of California, Berkeley. This article was condensed from an address delivered at the annual program meeting of the Council on Social Work Education in Los Angeles in January 1957.

Use of Behavioral Sciences

Grinkers,¹ the Talcott Parsons,² the Harold Wolffs,³ and others, some of whose beginning efforts are bent toward a better articulation of current knowledge now locked in the many compartments of the behavioral sciences.

To this expansive and unintegrated mass of concepts, hypotheses, and tested formulations about man, social work education is currently making a noble effort to relate itself. But social work education, in this very process, manifests most clearly its own internal divisions and divisiveness.

For each of the four fields of social work education—methods, social services, growth and behavior, and research—relates itself in a somewhat different way to the behavioral sciences. Social work research borrows logic, techniques, and illustrative studies. Growth and behavior seeks content on the family and on each of the stages of the life cycle.⁴ These courses then move rapidly into psychopathology. Preparatory to this, there is likely to be a review primarily of the Freudian theory of psychosexual development, which tells us little about the adult years, beyond the classic criterion that to be able to love and to work is to be mature. Senescence is a blank. The extent to which courses in the social services draw upon the behavioral sciences I do not know. In the methods courses, social work education tends to run the gamut of borrowings from psychoanalytic theory in casework, its social content taught in almost completely nonconceptual terms, to borrowings from

sociological theory in community organization, its psychological content crude and bare of relevant psychodynamic formulas.

The compartmental lines in social work education are thus accentuated by the diverse behavioral science roots each segment attaches itself to. The conceptual language used in each of the segments varies sufficiently to compound divisiveness; or else the language remains so vague and nonconceptual as to guarantee fuzzy thinking and poor communication, and thus the perpetuation of social work education's compartments.

A first problem, then, in the use of the behavioral sciences in social work education, perhaps too briefly stated, is the problem of segments. Here is where selective use of the behavioral sciences may serve a purpose.

That purpose is to provide social work education's segments with a unifying language useful to all its members, accommodating content in the three treatment methods as well as the social services, growth and behavior, and research—a language which enables social work educators to communicate more effectively, also, with members of their extended family in the behavioral sciences, and a language of somewhat greater precision than that now used by social work educators. Elements of such a language have been penetrating social work's ways of expressing itself for some years now, but with only limited acceptance and incomplete understanding of terms or their usefulness. A useful language provides keen tools for thinking. A useful language sharpens understanding of foci of concern and of ways for dealing with them.

Pollak,⁵ Greenwood,⁶ and others⁷ have

¹ Roy R. Grinker, ed., *Toward a Unified Theory of Human Behavior* (New York: Basic Books, Inc., 1956).

² Talcott Parsons and Edward A. Shils, *Toward a General Theory of Action* (Cambridge: Harvard University Press, 1952).

³ Leo W. Simmons and Harold G. Wolff, *Social Science in Medicine* (New York: Russell Sage Foundation, 1954).

⁴ "Who Should Teach What in Human Growth and Behavior," in *Towards an Integrated Program of Professional Education for Social Work: Summary and Findings of Four Workshops, Annual Meeting, 1952* (New York: American Association of Schools of Social Work, 1952).

⁵ Otto Pollak, *Integrating Sociological and Psychoanalytic Concepts* (New York: Russell Sage Foundation, 1956).

⁶ Ernest Greenwood, "Social Science and Social Work: A Theory of Their Relationship," *Social Service Review*, Vol. 29 (March 1955), pp. 20-33.

⁷ Grace Coyle, "New Insights Available to the Social Worker from the Social Sciences," *Social Service Review*, Vol. 26 (September 1952), pp. 289-

given thought to the use of behavioral science concepts and other scientific content in social work education. Such thinking leads to efforts to describe in behavioral science terms the major uniformities in the complex world of social work phenomena. What are these phenomena?

IDENTITY

My attempt has many manifest limitations. First, it is merely a sketch, many details of which require intensive study in the years ahead. Secondly, what I am presenting posits as the core of social work education what is called the social work "treatment" segment and almost completely neglects the broader field of social welfare. Thirdly, the basic treatment method in mind is casework, though parallels to group work and community organization are apparent where not explicit. With these limitations stated, I shall proceed with efforts to outline the identity of social work as a field of knowledge—that is, the substance of social work education—in terms which I believe will facilitate the organization and development of relevant knowledge, no matter what its source.

Erik Erikson has proposed that one establishes one's identity in adolescence by becoming clear, first of all, about who one is *not*.⁸ Social work knowledge is *not*, like the behavioral sciences, interested in understanding man under any and all conditions. Rather, social work's concern is with man's behavior in response to stressful conditions. Social work's basic knowledge is focused, then, on the dynamics of stressful situations

and especially on ways of preventing or ameliorating some of these conditions and their effects on man. The latter knowledge—the "ways-of" or methods knowledge—consists essentially of formulations about professionally guided social interaction, whether in casework, group work, or community organization. Ideally, the outcome of social work's efforts is personally and socially more satisfying social interaction so repatterned in the small groups and communities in which clients live that personal capacities, including knowledge of supportive social resources as well as the resources themselves, are strengthened for avoiding or coping more effectively with later stressful situations.

What are stressful situations that beset man? Threats to his physical integrity, threats to his self-images and central beliefs and values, threats to or failures in his major role-performances, and threats to or breakdowns in the structure or economic and other sociocultural processes of a community. For present purposes, each of these kinds of stressful situation can be given only slightly more attention.

Threats to physical integrity involve threats to life or physical well-being of a person or any member of a group with whom he is identified. In such situations, persons may come into contact with medical or governmental protective services prior to engagement with the social services. But the dynamics of stressful situations involving threats to physical integrity present diagnostic problems in all the methods of social work. What are the conditions of such stressful situations? What are the variety of ways in which man adapts and adjusts to such stressful situations? What is known in the behavioral sciences and what has been empirically learned in social work practice about such conditions and modes of reacting to them?

Threats to self-images and central beliefs and values about which personality or group life is organized arise under various conditions. In such stressful situations, so-

304. Alice B. Hyde and Jeane Murphy, "An Experiment in Integrative Learning," *Social Service Review*, Vol. 29 (December 1955), pp. 358-371. Katherine Spencer, "The Place of Socio-Cultural Study in Casework," in *Socio-Cultural Elements in Casework: A Case Book of Seven Ethnic Case Studies* (New York: Council on Social Work Education, n.d.). Herman D. Stein, "Social Science in Social Work Practice and Education," *Social Casework*, Vol. 36, No. 4 (April 1955), pp. 147-155.

⁸ *Childhood and Society* (New York: W. W. Norton & Company, Inc., 1950).

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cial services may be among the community's resources available for remedial or preventive action. We are dealing here with the developmentally inseparable forces of psychic and sociocultural processes. Under what conditions of psychic and social change do stresses of this type arise? How does man attempt to cope with them? How do the groups of which he is a member react—by support, by aggression or ostracism, by withdrawal? And under what conditions is one mode of adaptation or adjustment rather than another used? At what points may the professionally guided social interaction of social work methods be introduced to deal with what elements in such situations, and using what techniques?

Threats to or failures in role-performance arise when a person's accustomed behaviors associated with a given social position fail to reduce tensions in a situation, and either he or others in roles reciprocal to his role feel, to some extent, overwhelmed. The concept of role has been defined and discussed elsewhere in the social work literature.⁹ Examples of clients with problems in role-performance fill the working hours of case-workers in all kinds of agency—the child with behavior problems or without adequate parenting, the unmarried mother, the unemployed father, the foster parent, and so on. What are the sources of such stressful situations, and how is adaptation or adjustment made to them?

To what extent are threats to or breakdowns in the structure or economic and other sociocultural processes of a community related to failures in role-performance? Stress for the individual may initially be identified by ruptures in role-relationships in a small group or community—unprepared-for changes in the social structure, or the composition of a group, or the guiding

beliefs and values of a family. Breakdown in role-relationships may be a social condition which always accompanies stressful situations of concern to social work, though the triggering of the situation may be intrapsychic or biochemical.

Clearly, the identity of social work knowledge includes theory on stressful situations of each of the types mentioned. It includes, beyond this, knowledge of the professionally guided social interaction which is the treatment methods of casework, group work, and community organization, used to counteract or prevent the advent of stressful conditions.

Interaction between clients and social workers is thus one of the central foci in social work education. Clients begin such interactions in stressful situations or in anticipation of such conditions. Social workers approach clients armed with beliefs, values, and principles of action derived from the profession of social work. This is their reference group in social work interaction—the group whose identification they have taken on. Similarly, clients come with beliefs, values, and customs, learned in the course of socialization, in response to the expectations of their own sociocultural reference groups. Some of these beliefs and values directly affect what goes on in the helping process. That not all clients subscribe to similar beliefs, values, and customs, directly related to their use of social services is demonstrated in a series of studies done at Berkeley—Svarc's study of a group of Eastern European Jews' approach to the receipt of financial assistance,¹⁰ a study of the role of member in lower and middle-class group-work-center early teen-age clubs,¹¹ and the Berkeley-New York study of parents' expectations in regard to psychiatric clinic services for children.¹² Modes

¹⁰ Ivor Svarc, "Client Attitudes Toward Financial Assistance: A Cultural Variant," *Social Service Review*, Vol. 30 (June 1956), pp. 136-146.

¹¹ Henry S. Maas, "The Role of Member in Clubs of Lower-Class and Middle-Class Adolescents," *Child Development*, Vol. 25 (December, 1954), pp. 241-251.

¹² Henry S. Maas, *et al.*, "Sociocultural Factors in

⁹ Henry S. Maas, *Building Social Work Theory with Social Science Tools: The Concept of Role*. Special Report No. 41 Research Department, Welfare Planning Council, Los Angeles Region, 1954. Spencer, *op. cit.*

of adaptation and adjustment to stressful situations generally vary with sociocultural reference groups.

Supports and obstacles to the use of various modes of adaptation and adjustment vary, too, with the small groups of which clients are members—groups like the family and the work group, informal friendship groups, and more formal associations. Within these groups, and in the community, a person's major roles are performed. Here is where dissatisfactions are felt and directly or indirectly expressed. To the professionally guided social interaction of social work treatment situations, these obstacles and supports are, in essence, brought. Their dynamics affect what goes on in and what can come out of treatment.

Similarly, the social worker comes to treatment situations with the supports and obstacles of a membership group—that of the social agency of whose staff he is a member and whose policies and procedures make explicit many of the agency's role-expectations for him in interaction with clients.

Beyond these reference and membership group forces which affect treatment situations and inevitably their outcome, both clients and workers are affected in their interaction by unique constellations of biological and psychological factors. Age, sex, physical condition, intellectual capacity, and that still mysterious force we call vaguely physical energy are among the biological factors. The relevant psychological dimensions vary somewhat according to one's theoretical allegiances, but all usable systems give conceptual labels to (a) motivational forces, including innate and acquired drives and inhibitions, (b) affects, (c) executive capacities, which include perception, learning, memory, motor control, and problem-solving, and (d) some system of intrapersonal defenses which permits of perceptual distortions and other protections

against internal or external stimuli offensive to man's image of himself as a respectable and capable human being. In addition, all of this has a history in growth, maturation, and development, in a sequence of significant social situations.

Now all of these generalized variables or concepts represent conditions to be assessed in attempts to understand (or diagnose) the interplay of forces which affect modes of adaptation or adjustment to stressful situations. Among these modes are the use or development of social services. The central questions of social work education may then be phrased as: How and why do persons (both clients and workers), small groups, and communities act and react in stressful situations? What are significant conditions in such situations? And, most important, under what interacting conditions is social work action of a given type indicated?

Here, then, is one sketch of the identity of social work education.

SELECTION

The sketch just offered suggests broad questions about which social work educators might organize existing answers for reintegration and use in social work education. Let me illustrate these questions.

The first type of stressful situation previously cited involves threats to physical integrity. There are answers to questions such as the following, concerning this type of stressful situation. The sources cited are intended to be merely illustrative of the more readily accessible references, evidence of the assertion that the behavioral sciences do currently have some answers to such questions.

Tackling the problem of threats to physical integrity, one may ask, to start with, and still quite broadly:

1. How do threats to physical integrity—or, specifically, disease and physical handicap—relate to dysfunction in the larger social systems of which social work's clients

Psychiatric Clinic Services for Children: A Collaborative Study in the New York and San Francisco Metropolitan Areas," *Smith College Studies in Social Work*, Vol. 25 (February 1955), pp. 1-90.

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are a part? For specific classes of disease and physical handicap, what are the social correlates? These questions call for review of the sociological and especially the medical sociological literature. See Halliday¹³ and the almost fifty-page bibliography in *Social Science in Medicine*.¹⁴

2. How do threats to physical integrity, upon persons in small group situations, modify social interaction and its determinants in these groups? Here, the growing literature on the social psychology of illness and physical handicap is relevant; Roger Barker reviews and integrates a sizable portion of this literature.¹⁵

3. How do threats to physical integrity relate to psychic disequilibria? What are the psychological concomitants—cause or effect—of different classes of acute and chronic diseases? In addition to the psychoanalytic approach to such problems, there is the use of learning theory in such work as Ruesch's on thyroidectomized patients and patients with duodenal ulcer.¹⁶ Much of this content needs review for use in social work education.

4. What are major theories on the physiology of illness, theories which may give social workers the breadth of understanding they need without the medical details which only social workers in medical settings have occasion to use? Here resources are Cannon's basic work on homeostasis,¹⁷ and more recently such theories as Harold G.

Wolff¹⁸ and Hans Selye¹⁹ present, well within the comprehension of nonmedical people.

5. Finally, in situations of threat to physical integrity, how do persons' sociocultural reference groups affect their modes of adjustment and specifically their differential use of curative facilities—whether the resources of "folk medicine" or of scientifically based modern medicine—and related services? Anthropologists are providing a growing literature on this problem. Lyle Saunders' recent book²⁰ is probably most accessible to social workers.

Then, given what is known now about relationships between situations involving threats to physical integrity and (a) societal imbalances; (b) disequilibria in small group life—e.g., the family, the work group, the school group, friendship groups, and in medical facilities themselves; (c) psychic malfunctioning; (d) relevant physiological theory; and (e) cultural variations in the use of modern medical and other curative services, what are the implications for the organization and development of related social services? Applying its own values and knowledge, social work may then ask and propose under what conditions and at what strategic points, on the pathways followed by ill persons, their families, and their communities, social services should be available; and what their goals should be; and how these goals should be achieved.

This broad format of questions can be modified to guide the selection of relevant behavioral sciences content for each of the types of stressful situation cited, and for each of the uncited subtypes. The job to be done is obviously a large one; I know of no substitute, short-cut approaches. The plan obviously requires more time in the library,

¹³ James L. Halliday, *Psychosocial Medicine: A Study of the Sick Society* (New York: W. W. Norton & Company, Inc., 1948).

¹⁴ *Op. cit.*

¹⁵ Roger G. Barker et al., *Adjustment to Physical Handicap and Illness: A Survey of the Social Psychology of Physique and Disability*, Bulletin 55, revised (New York: Social Science Research Council, 1953).

¹⁶ Jurgen Ruesch, "Social Technique, Social Status, and Social Change in Illness," in Clyde Kluckhohn, Henry A. Murray, and David M. Schneider, eds., *Personality in Nature, Society and Culture* (New York: Alfred A. Knopf, Inc., 1953).

¹⁷ Walter B. Cannon, *Wisdom of the Body* (New York: W. W. Norton & Company, Inc., 1939).

¹⁸ *Stress and Disease* (Springfield: Charles C Thomas, 1953).

¹⁹ *The Stress of Life* (New York: McGraw-Hill Book Co., 1956).

²⁰ *Cultural Differences and Medical Care: The Case of the Spanish-speaking People of the Southwest* (New York: Russell Sage Foundation, 1954).

if less time on committees. And the job is one which is never done completely, for once organized, such content must be open to modifications of conceptual framework as well as the findings of continuing research in the behavioral sciences, as such research expands, refines, or otherwise alters existing formulations.

REINTEGRATION FOR USE

In moving from the selection and ordering of behavioral science formulations to the procedure of reintegrating such content for use in social work education, one moves from generalizations about, for example, disordered social structures to diagnostic theory on types of disorganization of the social services or unmet community needs in recognizable classes of community. Or from generalizations on role-conflict and role-incompatibility, one moves to types of failure in role-performance found among social work's current or potential clients. For in terms of purposes, knowledge that is to be useful to social work must be on a sufficiently specific level to guide social work practice and the organization of social services.

I assume, moreover, that increasingly social work theory should stipulate that under these diagnostic conditions, this is the course of treatment action to be taken; under those diagnostic conditions, that is the course of treatment action to be taken. As the relevant and modifiable conditions in stressful situations are analyzed and their interrelationships ordered, with the help of the behavioral sciences, social work diagnostic theory should take on greater and greater refinement. Such formulation, coupled with guides to action, may be used as the basis for professional judgments in treatment planning and the art of practice.

The propositions that guide social work practice are if-then propositions. The if's of clients' stressful situations must include all elements germane to the course and goals of treatment. Social work tries to modify through treatment certain kinds of

stress-inducing social conditions—for example, the inappropriate expectations of parents, teachers, or employers for the role-performance of a child, a pupil, or a worker; the values of a group of delinquents; the inappropriate beliefs of board members in an agency which has outlived its usefulness to the community; inequities in public assistance regulations. Social work education should therefore formulate for and teach its students about the dynamics of such situations and how, under given combinations of conditions or if's, they then may be modified.

Let me cite an example of current deficiencies in if-then propositions in social work, suggesting failure to reintegrate for use relevant behavioral science knowledge, and to conceptualize treatment formulations accordingly. Currently, the if's in diagnostic theory in casework make little conceptual use of any but psychiatric formulations. Specifically, social work's model efforts, by Florence Hollis²¹ and the Pittsburgh School²² to define how treatment varies as clients' diagnostic conditions vary, describe these conditions in almost completely psychiatric terms. Conditions related to clients' social class—e.g., possible social mobility—reciprocal familial roles, and physical conditions receive, at best, secondary and nonconceptual attention. The extent to which characteristic or unique modes of social interaction in the family or the larger community entered into the clients' past adjustments to stressful situations is given no systematic attention. Diagnostic theory drawn primarily from psychiatric theory cannot account for such forces. A broadening of the behavioral science bases for social work's diagnostic theory should bring social work educators,

²¹ "The Techniques of Casework," in Cora Kasius, ed., *Principles and Techniques in Social Casework: Selected Articles 1940-1950* (New York: Family Service Association of America, 1950).

²² Eleanor E. Cockerill et al., "A Conceptual Framework for Social Casework: A Suggestive Outline" (School of Social Work, University of Pittsburgh, 1952). (Mimeographed report.)

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at least, to a clearer if not more catholic approach to the teaching of social casework. What is being drawn on in psychiatric and specifically psychoanalytic theory is, of course, readily accessible and integrated content. It is taught and used, so far as I can see, in almost unaltered form. It may even now be studied in graduate social work education to the point where its deeper-level formulations can have little applicability for the social worker who is not practicing psychotherapy. Concentration on details of the genesis and dynamics of all forms of psychopathology, when social pathology goes almost untouched in most graduate schools of social work, suggests that social work education has uncritically taken an easy way out. Certainly the caseworker diagnosing a client's stressful situation—that is, the person in his social context—needs more than psychiatric concepts.

For, additionally, the caseworker might ask, in what social roles is the client experiencing personal or social dissatisfaction? In what, if any, personal or social satisfaction? Where in the client's stressful situation is there conflict or incompatibility in roles? To what extent does he need help in the modification of the expectations of others in roles reciprocal to his? To what beliefs and values, relevant to his current situation, does he subscribe? Are they supportive or nonsupportive in the current situation? In what groups is he a significant member, and to what extent are these groups supportive or nonsupportive of him in the current situation? The social caseworker should understand the workings and effects of such social forces in the lives of clients and be able to deal with them, directly or indirectly, in treatment. Clearly, the conceptualization of these forces has a place in social work's diagnostic theory, in a matrix of relevant scientific formulations about their variable relationships.

If currently in social work education in-

structors in casework make little use of social structural concepts such as social status, and the dynamics of status or social role; concepts of sociocultural process such as social mobility and value-conflict; and concepts relating to small group and intergroup life, these are the very concepts which good group work and community organization teachers hang their practice theory on. But if one finds increasing use of social dynamic concepts as one moves from individually oriented casework courses to the group work and community-oriented courses, one finds decreasing use of psychodynamic concepts, as though psychodynamics did not operate or were not relevant in community organization practice. For example, Murray G. Ross's book in community organization²³ makes good use of the previously cited social science concepts and related formulations, but in the psychodynamic area Ross discusses only the vague idea of "individual's predispositions." I think there is a good reason for this state of affairs. What is currently offered as psychoanalytic content in some schools of social work often does not seem compatible with social theory. This is where Erikson²⁴ or Sullivan²⁵ has as yet made no impression on the self-sufficient, psychodeterministic, and outdated Freudian theory being taught.

I should not conclude without repeating the warning that there will be deficiencies in the behavioral sciences, too, for social work education's purposes. Clearly efforts at integration for use will turn up many unanswered questions. But social work educators, having made such efforts, will know that their students—and the field—are profiting from what the behavioral sciences currently have to offer one field of action.

²³ *Community Organization—Theory and Principles* (New York: Harper & Brothers, 1955).

²⁴ *Op. cit.*

²⁵ Harry Stack Sullivan, *The Interpersonal Theory of Psychiatry* (New York: W. W. Norton & Company, Inc., 1953).

BY PHYLLIS R. OSBORN

Meeting the Needs of People: An Administrative Responsibility

"A CAUSE," SAID Porter Lee, "is usually a movement directed toward the elimination of an entrenched evil. This may seem a narrow conception, since many of the historic causes of mankind have been directed toward the establishment of a new way of meeting human need or a new opportunity for human satisfaction. . . . [but] Whether we emphasize the elimination of evil or the establishment of a positive good as the objective of the cause, it seems to be true that once the elimination of the evil is accomplished, once the new positive good is established, interest in it is likely to slacken. The momentum of the cause will never carry over adequately to the subsequent task of making its fruits permanent. The slow methodical organized effort needed to make enduring the achievement of the cause calls for different motives, different skill, different machinery. At the moment of its success, the cause tends to transfer its interest and its responsibility to an administrative unit whose responsibility becomes a function of well-organized community life."¹

Most social agencies, perhaps all, came into being because of the vision of concerned men and women of the community who believed in a cause, who worked tirelessly to transform their concern and vision into a program and an administrative framework through which certain needs of

their fellow men could be met. This tends to be the pattern whether the sponsoring group is made up of laymen, who may later constitute the first board of a private agency, or citizens who indicate through their elected representatives their willingness to be taxed to care for those who lack resources to purchase the necessities of life, or who are sick or handicapped or the victims of troubled or broken homes.

A social agency thus created assumes responsibility for "meeting the needs of people," often not only those needs envisaged by its founders but also those unanticipated needs which develop with changing times and increased understanding. At its inception the agency is the creature of the community or of some segment of it. It is and must continue to be an integral part of the community, responsive to its needs and sensitive to its guidance. The agency must also offer leadership for further needed action, progress, and achievement in the area of concern that the community has entrusted to its care.

The agency bears the responsibility for translating community concern into warm and purposeful relationships with troubled men, women, and children. To the agency falls the difficult and often unglamorous task of capturing the exuberance of "cause" and molding it into the day-to-day, repetitive efforts needed to translate the high hopes of the supporters of a cause into services of a quality commensurate with those

PHYLLIS R. OSBORN, M.A., is professor in the School of Social Service Administration, the University of Chicago. This paper was presented at the Iowa Conference of Social Work, Des Moines, in November 1956.

¹ "Social Work: Cause and Function," *Proceedings of the National Conference of Social Work* (Chicago: The University of Chicago Press, 1929), pp. 3-4.

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hopes. More often than not, the nature of the efforts necessary has not been anticipated fully by the founding group. The enormity of the agency task is one to give us pause, except that there so seldom seems time in the hectic scene of agency operation for pause of any nature. Perhaps this is one of our basic problems as board members and social workers. We so seldom find or make an opportunity to take a systematic backward look at the road over which we have come, in order to plan more effectively for the future. When we are submerged in the crises that each day brings, it is difficult to rally the necessary self-discipline involved in an over-all evaluation of our activities—of the extent to which our definitions of function, our policies, our methods of operation, and our available resources and existing personnel practices help or hinder in accomplishing the avowed purposes of the agency.

A social agency is an organization of people brought together for the purpose of administering certain more or less definitely defined social services. The actual translation of "cause" into day-by-day services involves the total of all agency effort. John A. Veig, a political scientist who has been an active student of administrative management, although not a specialist in the welfare field, describes administration as a process "aimed at making those things happen which we want to happen and preventing developments which fail to square with our intentions."² He further observes that "motivated by their desires and interests individuals and groups of individuals set themselves their main goals—what they do thereafter to translate these goals into positive achievements is essentially administration." Regardless of our personal convictions about the administrator as generalist versus the administrator as specialist, we might well examine current practices in

both public and private agency administration in the light of these generic definitions. To what extent are our administrative processes and policies, both legislative and agency promulgated, aimed at "making those things happen which we want to happen and preventing those developments which fail to square with our intentions?"

TESTING PRACTICE AGAINST PURPOSE

We may attempt to answer this question by briefly examining, for example, just a few aspects of the program of Aid to Dependent Children, which is operating in every state in the country. The quality of the basic services available through this program has a significant impact upon the program of every social agency, public or private, which offers services to children and aims at strengthening family life.

The eligibility requirements, other than need, that were included in the act at its inception have impeded rather than advanced the purposes of the program. Within their restrictive confines, the father who feels less than adequate must disappear from the scene or escape into continuing illness or incapacity in order to establish the eligibility of his needy family for assistance and services. This parent, whose skills, abilities, and adjustment to life are too limited to enable him to take full responsibility for his family, could often, with some supportive help from the agency, make a substantial contribution to their needs, both as breadwinner and as parent. Without the psychological hazards involved in the present requirement of the father's "absence from the home" and "incapacity," financial assistance and casework services as needed might well result in a larger proportion of cases being restored to financial independence than is now the case. Should not agency responsibility encompass undertaking and publicizing systematic and objective studies of the effects of these eligibility requirements, which deny aid to a needy child because his father has not deserted

² "The Growth of Public Administration" in Fritz Morstein Marx, ed., *Elements of Public Administration* (New York: Prentice-Hall Inc., 1946), p. 3.

him or has not proved to be sufficiently incapacitated to meet agency standards?

When Old Age and Survivors Insurance matured to the point of removing from the ADC rolls most of those children whose parents were respectably dead, an inevitable increase resulted in the percentage of caretakers remaining on the rolls who displayed problems of serious maladjustment and behavior no more admirable than those evidenced by many less needy individuals in the community. Many agencies became apologetic and guilt-ridden because of this. Yet social agencies exist only because a community has recognized the existence of a social problem and has indicated a desire to alleviate it. Surely, then, no social agency need be apologetic when to its doors come people who are perhaps out of conformity with community standards of approved behavior, and who are unable to cope unaided with their dilemma.

The stirrings of community conscience which underlie the establishment of any social agency have their selfish as well as their altruistic aspects. To take an extreme example, feeding the starving and treating the sick may represent sincere concern for one's fellow men but it may also protect individuals and property from lawlessness and revolution, and healthy persons from the ravages of disease. Less obvious examples of the duality of concern could be cited as inherent in any social agency effort. Often agency representatives are troubled by the apparent conflict between what they see as their responsibility to protect their sponsoring group and their responsibility to give needed financial assistance and other services to their clients. In reality, these responsibilities are indivisible. Agency practice cannot be such as to render a disservice to one group without adversely affecting the other. This holds true whether the agency is tax-supported or dependent upon private contributions for its support. However, taxpayers, who are the contributors to a publicly supported program, are inevitably a group less homogeneous in their

thinking and understanding than supporters of a private agency, who come together voluntarily because of interest in a common cause. All public program legislation in a democracy evolves out of conflict and differences of opinion—and the public agency, if it weakly pursues or even undermines its avowed goals in its attempts to please all holders of every shade of opinion, frequently ends by pleasing no one and defeating the purpose of its reason for being.

Some time ago, when the attacks on the ADC program were at their height, two articles appeared in a newspaper of a mid-western town on the same day. The first charged the public welfare agency with being the cause of illegitimacy because it was fulfilling its responsibilities under the law in granting needed aid to unmarried mothers and their unfortunate offspring. The charges ignored the fairly well-known facts of life underlying this problem, which has been with us quite consistently since there have been men, women, and marriage. Also ignored were the social breakdown so prevalent in our war, postwar, and future-war world and the mass migrations which are such a significant part of it. On a succeeding page in the same issue, an extensive article sympathetically portrayed and lauded the effective humanitarian efforts of a Red Feather agency for the services that it was rendering to the community and to unmarried mothers and their helpless and blameless children. This agency had made a practice of sharing with the public the nature of the difficult problems which confronted its clients, and had made known the methods by which it had attempted to discharge its stewardship. The public responded accordingly.

Agencies administering public welfare programs, laboring under extremely heavy workloads that involve almost every type of known social problem, have often failed to keep the community informed of developments in their programs, of the purposes of their efforts, of the human side of the problems with which they deal. Beset by

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partisan political attacks and those of vested interests, they have sometimes sought refuge in aligning themselves with these criticisms or have been inclined to go apologetically about their jobs, especially in their work with unmarried mothers or other non-conforming clients. Objective study of the causative factors in the unacceptable behavior, the social disorganization, the economic and emotional deprivations which lie at the source of such problems should be an agency priority. Sharing with the public knowledge of the extent to which community resources meet community needs and an evaluation of agency efforts to help in the solution or mitigation of these problems is one of the important problems of administration.

Just as the physician must sometimes face defeat in the problems of illness which confront him, either because he does not at the moment possess the knowledge and skill necessary to treat the ailment successfully or because the illness is a hopeless one, so must the social agency and the community supporting it recognize their limitations. If this admission results in continuing efforts to push out the frontiers of knowledge, to develop necessary skills, to keep trying, even in the face of almost foregone defeat, no guilt need ensue.

Very often in agency practice we do see such unjustified feelings of guilt resulting from failure to find successful solutions to complex social problems. They frequently find expression in the form of punitive and restrictive policies, which defeat the basic purposes of the program, of eligibility requirements which bar from service the very persons who need it most, or of useless red tape which consumes energy of both worker and client that might much more profitably be put to other use.

No substandard home was ever converted into a good home by withholding needed financial assistance. The "unsuitable home" may become through agency help the best possible home for a given child, though it may still be less than perfect. We no longer

remove children even from homes which leave much to be desired with the gay abandon of our first flush of enthusiasm about the miracles to be wrought through foster home placements. However, the home which is unsuitable to receive a money grant is unsuitable as a home for children. In some instances, both grants and children continue in homes that offer no possibility for a decent life. Foster home care and foster home costs must be recognized as essential to any comprehensive system of social services for children. Tax-supported efforts must inevitably be responsible for a large proportion of the costs if such needed services are to be available on a state-wide basis.

In our testing of practice in ADC against avowed purposes, we shall find several bright spots on the public assistance horizon today that may well prove to be of especial significance in this program. The 1956 amendments to the Social Security Act put additional and greatly needed emphasis on the service aspects of the four categorical assistance programs. Increases in payments become possible in many states as a result of changes in federal matching formulas. Additional federal grants specifically earmarked for matching state expenditures for medical care have been made available for the first time. Unfortunately, those states in greatest need, with fiscal resources so limited that they were unable to take full advantage of the earlier formulas, will not benefit to the extent desirable from the additional federal matching funds. However, numerous recipients in many states should benefit unless the states reduce their contributions to the program. Congress, in the 1956 amendments to the Social Security Act, also authorized grants for training workers in public assistance and for research or demonstration projects such as those relating to the prevention or reduction of dependency, but to date has made no appropriations for these purposes.

However, it is important to remember that congressional *authorizations* for expenditures, indulged in *before* elections, do

not necessarily result in congressional *appropriations* of hard cash *after* election. State welfare departments and other concerned organizations and individuals should make strenuous and continued efforts to assure translation of congressional intent into needed appropriations by letting their congressmen know their desires and their needs. Plans must be developed that will assure imaginative and productive use of these funds in increasing staff competence and in research and demonstration projects directed toward more effective solutions for the many problems that confront us today.

We have examined only a few aspects of the ADC program to illustrate certain areas in which practice might well be tested against purpose. Such testing should be a continuous process inherent in program operation.

STAFF PARTICIPATION

Administration should be an enabling process. On its quality depends the extent to which the skills and abilities of each and every staff member may be used in furthering agency goals. Often social workers have thought of administration as the enemy of professional competence rather than as the facilitative framework within which effective services to clients can be channeled and supported. It is not difficult to point to illustrations of agency practice that would substantiate such a belief, but often upon honest self-evaluation practitioners find that they have also played a part in fashioning the unhappy situation in which they find themselves. Social workers have traditionally regarded administration as exclusively management, as something that is done for them or to them, rather than by them. This idea is reinforced by the tendency to develop a managerial group in welfare with a set of values different from those of the practitioners on the staff.³

³ Wayne Vasey, "Partnership between Administrator and Staff in Developing Sound Welfare Programs," *Social Casework*, Vol. 33, No. 4 (April 1952), pp. 135-136.

Our transmittible body of knowledge related to the principles underlying effective social agency administration has in the past been meager, but it is increasing. Schools of social work are incorporating in their curricula courses designed to develop in their students an understanding of the administrative process and of the implications of the basic concept that each agency employee plays an important role in administration, whether as janitor, as executive, as supervisor, or as caseworker. In these courses emphasis is also placed upon the contribution that the knowledge, skills, abilities, and attitudes which are the objectives of all aspects of curriculum content should make toward facilitating the administrative process. Board members, executives, and practitioners are increasingly meeting together in workshops, in institutes, and in more informal settings to share their problems and to seek more effective ways of providing a setting, a climate, and a system of relationships through which "meeting the needs of people" may be facilitated rather than impeded by administration.

Current thinking on the problems of social agency administration leans heavily, in its genesis, on the writings of Mary Parker Follett, a most remarkably thoughtful woman who was born in Boston in 1868 and died in the early 1930's. She was a consultant to business and industry primarily, although she was also greatly concerned with the social problems of her community. Through close observation and keen sensitivity she discovered and formulated truths regarding administrative practice, as related to the goals of organization, which are still far in advance of the general level of thinking and practice today. Miss Follett's basic thesis stressed the constellation of ideas which centered in her belief that organization and administration will succeed only to the extent that each individual participating can be motivated and enabled to make his maximum contribution as an effective member of the group and of so-

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ciety. She saw administration as a continuous process of problem-solving with this end in view, and she believed that the basic principles involved in achieving these objectives were sound in any situation in which people were consciously striving to achieve established organization goals.

Miss Follett was not a "group worker" as we would use the term today, but her theoretical formulations do portray administration as a "group process" ⁴ in which every employee plays a significant part in line with his defined function. The current and growing body of knowledge related to the dynamics of human behavior further illuminates Miss Follett's pioneer efforts. A social agency is an organization manned by people who behave like people and who have all the needs, strengths, and weaknesses of people. Knowledge of the cause and effect relationships in human behavior is not used in administration for therapeutic purposes, as in casework or psychiatry or even in group work, but it can be used to facilitate the administrative process and to enable each employee to make his maximum contribution to this process.

As persons in management positions increasingly accept the idea of administration as a group process in which each agency employee plays a defined, essential, and respected role, rather than a set of duties performed exclusively by executive and supervisory staff, assigned tasks take on new significance. Appropriate staff participation in agency planning and operation becomes a reality that enriches individual capacities and furthers agency goals.

DIFFICULT BUT REWARDING

In conclusion, let us return for a moment to the previously cited and overly simplified

⁴ Harleigh B. Trecker, *Group Process in Administration* (New York: The Woman's Press, 1950).

description of administration as "a process aimed at making those things happen which we want to happen and preventing developments which fail to square with our intentions." It is easy to give casual and thoughtless acceptance to the validity of this statement, without any realization of its implications for practice. An honest testing of total agency administration against the concepts underlying such an approach to the administrative process will be an extensive and difficult, but often extremely rewarding undertaking. Measurement of program operation against such a yardstick will often, if conducted with intelligence, imagination, and integrity, necessitate basic changes in agency practice. Established policy will frequently be found to be antithetical to avowed agency purposes, and hence in need of revision. Modifications may be essential in organizational setup, in financing, in personnel standards and practices, in staff training activities, and in the research and public relations efforts.

It is, of course, self-evident that the day-to-day work of the agency cannot be brought to a standstill to make way for this evaluative effort. Often such an undertaking can proceed only by bits and pieces, but an overall plan into which these bits and pieces fit is essential to maximum productivity. If each person carrying responsibility for any aspect of agency program has an opportunity to share, in a manner appropriate to his function, in the promulgation of the plan and in the subsequent evaluation process carried on under it, agency administration and program will in all likelihood be greatly strengthened. This will be due not only to the end results of such activity but also to the by-products of staff participation, staff development, and staff morale which will accrue along the way.

GROUP WORK SECTION

BY HYMAN J. WEINER

Group Work and the Interdisciplinary Approach

GROUP WORK, A new arrival on the scene in treatment-centered programs, is attempting to establish itself on the interdisciplinary team. In this process, it has influenced the functioning of the collaborating professions, and in turn, has itself been affected. This impact of the interdisciplinary approach upon group work theory and practice requires systematic study and definition.

Group work practice is not fundamentally altered in different settings; essentially, it is still composed of the same ingredients. Although there are special features in any situation, it is erroneous to consider that these features fall into two broad classifications, *i.e.*, in either the special or traditional setting. Professor Clara A. Kaiser stated the following:

Within the last few years there has been a major trend to distinguish between the

practice of group work in so-called traditional settings and in special settings. Although this distinction is now generally accepted in the field, there is considerable confusion as to what it means for the development of the more effective practice of group work both in a generic sense and in relation to the specifics pertinent to special programs.¹

There are many ways of approaching this definition. Agency function is often used as the prime criterion. "Treatment" as opposed to "leisure-time" is a limited, though a more valuable yardstick than "special" as contrasted with "traditional." But here, too, our definition breaks down. When one examines these treatment settings more closely, one finds that the residential treatment home for disturbed children is qualitatively different from the psychiatric hospital, that a rehabilitation center for the physically disabled may be as different from a general hospital as both are from a leisure-time agency. Since agencies cannot logically and consistently be divided into cate-

HYMAN J. WEINER, M.S.W., is field instructor at the New York School of Social Work, Columbia University, currently supervising a student unit at the Bird S. Coler Memorial Hospital and Home on Welfare Island, New York City. The project described in this paper was carried out while he was senior group worker in the Rehabilitation Department of the hospital.

¹ "Development of Group Work Practice in Special Settings," paper presented at the New York State Welfare Conference, New York, N. Y., December 1956.

EDITOR'S NOTE: This article and those following it were chosen by the Publications Committees of the indicated Sections of NASW in accordance with a policy approved by the National Board of Directors.

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gories, depending upon their function, on what basis can they be defined in terms of group work practice? The accumulation of experience seems to verify that one feature abounds more frequently in a treatment than in a leisure-time setting. That feature is the incidence of group work as one service on a formal interdisciplinary team. The experience of this writer on such teams in one hospital setting is the frame of reference for this discussion.

Bird S. Coler Memorial Hospital and Home is a 2,000-bed municipal hospital for chronic diseases featuring a 250-bed child and adult rehabilitation service. Group work, a service now functioning four years with children and one year in adult rehabilitation, is directed toward patients with severe disabilities—cerebral palsied, amputees, and hemiplegics. The average length of patient stay ranges from three to nine months. The team approach is used throughout the rehabilitation service.²

What is the impact of the interdisciplinary approach on group work theory and practice? This impact seems to have the following effects:

1. It necessitates a study of the nature of teamwork in order to establish a group work service.
2. It calls for a sharply defined goal-conscious method of work, stressing skill in diagnosing individual and group behavior and the focused use of recording.
3. It raises the following question of the generic base of social work: *Should group work take its place on the team as an integral part of the medical social work service?*

The above questions force a closer look at the nature of teamwork and the specific function of group work on the team.

² The variety of teams at Bird S. Coler Hospital includes physicians, nurses, occupational speech and physical therapists, psychologist, rehabilitation counselor, medical social workers, recreation leaders, dietitians, and group workers. Not all disciplines participate on every service.

Whereas teamwork is a network of many levels and types of interdisciplinary co-operation, the team meeting is only one aspect of this network. The group worker as a new addition to the team brings a new approach with him. Whereas other disciplines serve the patients individually, the group worker brings the group approach to bear.

The patient, transformed from a normally functioning individual to a handicapped person, is at a turning point in his life. Living in a hospital under a high degree of stress with other disabled patients on a ward can become a positive or negative force affecting his participation in the rehabilitation program. His motivation toward rehabilitation depends, in part, upon the particular group he responds to in his current hospitalization.

The prime group work goals in this rehabilitation service are:

1. To effect positive group norms so that patients will motivate each other in the rehabilitation program.
2. To form groups so that the patients can relearn social life as disabled people.
3. To employ the group to resolve anxieties and prevent pathology by building upon the strengths of the individual.
4. To exploit the current hospitalization with the group to bridge the return to the community.

The group worker planfully harnesses the group life of the patients and helps them to help each other through the rehabilitation program.

In the final analysis it is the successful demonstration of the group work method on a case-by-case basis that enables the social group worker to become an accepted member of the team. Our experience points to the fact that even this ability to demonstrate service depends, in large measure, upon the effectiveness of team functioning. What are the considerations involved that will enable the group worker to function as an integral part of the team apparatus?

FUNCTIONING AS PART OF TEAM

Our assumption is that the nature of our discipline leads to overlapping with areas previously reserved to the nurse, caseworker, and recreation leader. Thus the addition of group work to the team results in role confusion and interdisciplinary conflict. The resolution of this conflict, a positive dynamic, serves to raise the level of teamwork. In view of this, aside from the team meeting, the group worker must discover methods for linking his work with other individual disciplines. At Coler Hospital, this has been achieved through a psychosocial case committee and the formation of a team subcommittee to deal with group living problems on the ward. This is not to underestimate participation at the formal large team meetings, but demonstration of service can, in many ways, more effectively be accomplished outside this structure.

The different interdisciplinary contact points depend upon the nature of the group work service offered. At Coler Hospital, group work takes place on three simultaneous levels within the rehabilitation program. These are:

Total ward. The development of a patient-ward committee that takes responsibility for recreation planning, orientation of new patients, and resolution of group living problems.

Counseling groups. Formation by the group worker of particular small groups for counseling purposes around problems of discharge, anxieties related to treatment, and so forth.

Interest groups. Specialized recreational groups, such as group games, music appreciation, and current events.

This three-dimensional approach opens many avenues for interdisciplinary cooperation directly on the practice level. In order for the group worker to function effectively on the total ward level, close contact and shared responsibility with the physician, nurses, lay administrators, and

caseworkers are crucial. A therapeutic milieu cannot be shaped by any one discipline. The nursing division is the backbone of the ward structure and careful planning around its involvement in the group work program has been found to be most beneficial. A team subcommittee is beginning to emerge that concerns itself with ward problems and programs. When the group worker reports to the total team, daily experiences of at least four other disciplines have been evaluated. Thus, the patient-ward committee and other groups that the worker talks about are more readily understood. Most important, the other disciplines participating in this small committee begin to appreciate the impact of the patient group on the rehabilitation program. The group worker can concretely demonstrate the operation of particular subgroups on the ward which serve to generate negative patient values and pessimism.

On the counseling level, a psychosocial case committee is the major contact point of the group worker with the psychologist, rehabilitation counselor, caseworker, and psychiatrist. Individual and group goals can be discussed more effectively in this kind of a staff grouping. Reshuffling of roles is more easily accomplished when there is no intervention of the total power structure of the team.

On the interest-group level, contact with the physical therapies is made possible. The patient's group is the functional context in which the gains made in the therapy gyms are maintained. These are only the broad guidelines outlining the emergence of the group worker as he contributes to the full breadth and scope of teamwork.

One major obstacle encountered was the limited view of the team as merely a co-operative endeavor. Grace Coyle makes the following observation:

... it would seem that the self-awareness of a team member is greatly enhanced and his contribution to the team is improved if he is able to see how and why the team functions as it does. The

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status structure among members, the problems of different professional languages, the use of authority, the state of the group's morale may all give him some clues as to how the team may progress toward its goal.³

By definition, a medical setting is a bureaucratic structure. The patient focus demanded of the team is impeded by departmental and professional allegiances that arise. On each separate ward the different teams develop their own status system, ranking order, and vested interests. The group worker usually finds himself aligned on the status level with the occupational therapist and recreation leader. The middle status group usually consists of the psychologist, medical caseworker, and physical therapist. The prime status post is filled by the physician. Thus the team reflects both the power structure of the total hospital as well as of any particular ward. Teams cannot be seen only as collections of personalities with or without co-operative spirit, but rather also necessitates the perspective of the team as a *group* functioning within a bureaucratic setting.

GOAL-CONSCIOUS METHOD

Let us now investigate the second question, namely, the goal-conscious method of work. A group work service in this interdisciplinary setting must be offered within a defined medical-social treatment plan. Faced with this situation, group workers must clearly state their individual goals for the patient as well as the specific steps by which they hope to arrive at them. Both are important, for our goals must flow from the basic treatment plan. The method of arriving at these goals must be shared with the team, for it is the different way we arrive at similar patient goals that distinguishes the group work service from

other related disciplines. The fact that the group worker is *accountable* to the team implies that his goals must not only be defined but his progress in achieving them must be reported back. His ability in diagnostic skill (at the core of his work) will determine his ability to accomplish this.

One obstacle that seems to retard the group worker's ability to improve diagnostically is the current level of group work recording. The recent era in the development of social group work evolved the process record. This narrative approach to recording reflected a beginning stage in our profession when the understanding of group process was limited. Group work recording, in its present form in this medical setting, has been found inadequate both as an aid for team communication and as a method for improving day-to-day group work practice and diagnostic skill. Henry W. Riecken summarizes the situation well:

... it is not clear just what the observer is observing, or whether he is paying attention to "important" things. In fact, under these conditions of observation it is rarely possible to specify what the important events are or why the observer chose to note what he did. Neither he nor anyone else can tell, because there has been no explicit frame of reference for observation. He saw what happened to strike him, what his pre-existing values directed him to see or fail to see.⁴

Our field should now be prepared to enter a second stage of development, a stage in which group process is recorded more selectively, in which goals are clearly stated along with concrete steps for their implementation. Our increasing knowledge of small group theory should make the second stage a reality. At Coler Hospital the group work service is currently developing several methods of recording for different

³ "A Study of Group Process," in Grace Longwell Coyle and Margaret E. Hartford, *Social Process in the Community and the Group* (New York: Council on Social Work Education, 1958), p. 73.

⁴ *The Volunteer Work Camp: A Psychological Evaluation* (Cambridge, Mass.: Addison-Wesley Press, Inc., 1952), p. 6. (Quoted by Jacob I. Hurwitz, "Systematizing Social Group Work Practice," *Social Work*, Vol. 1, No. 3. (July 1956), pp. 66-67.)

purposes. Essentially, two types are emerging: one for interdisciplinary communication and the other as an aid to daily practice. Team reports, of necessity, must be brief, clear, and directed to concrete goals. Other members of the team do not have the time to read lengthy group and individual reports. Clearly focused recording is in large part dependent upon diagnostic ability, but attempts to record more selectively should, in turn, increase our diagnostic skill.

SOCIOLOGY OF HOSPITAL LIFE

Another area of interest in this medical setting is the deeper understanding of the sociology of hospital life required of the group worker. It is here we find a major theoretical gap. Coler Hospital functions as a small society with its transmission of cultural patterns and particular sets of patient and staff values. The interrelationship of a particular group to the total hospital culture must be carefully appraised by the group worker before he attempts to affect it. This calls for skill in diagnosing groups. There is much emphasis in the literature about increased individualization in treatment settings. But even this work with individuals is dependent upon skillful work with the group as a whole. Individualization does not lead to the dilution of the worker's focus on the total group. The problem we face at Coler is that the group workers seem poorly prepared to function diagnostically. Behavior, both individual and group, tends to be described in broad generalizations and the result is a superficial survey of patient needs and problems. We find there is need for deeper skill in diagnosis of pathological behavior in the treatment-centered setting. The mental hygiene foundation of our method is not contradictory to the ability to diagnose and deal with pathology.

We must appreciate the variety of benefits inherent in all types of group life and

be able to harness the group energies on each level. We very often approach group life from a vantage point that is limited because of definite historical prejudices. Our understanding of group life has emerged from our experiences in leisure-time settings. The application of this understanding in treatment settings, however, calls for a reappraisal in its special application. Very often, the formation of small groupings, when achieved, is conceived to be the highest level of accomplishment. We tend to approach all groups with the same traditional criteria: small size, increased interaction, relaxed atmosphere, and degree of group identity. Our experience on the wards indicates that individuals make use of a variety of group experiences for many different reasons. A total ward group is an active force in the socialization process and should not be relegated merely to "ward climate" or considered only as a reservoir from which the small group can be formed. The anxiety-ridden, newly admitted patient can often be helped through the loosely formed ward social life in contact with one or two other patients. He would not benefit from an experience in a small group that he thinks implies a long-term stay. At a certain point in the treatment process, a small group experience meets his need to test himself as a disabled person in a more intimate social unit.

RELATION TO MEDICAL SOCIAL WORK

The final question raised by the interdisciplinary approach is: *Should group work take its place on the team as an integral part of the medical social work service?*

Professor Kaiser, reporting on a meeting of group workers in treatment settings, states as follows:

Group work is sometimes included under the social services and is sometimes separated from a casework program. It was generally agreed that the most effective integration of casework and group work

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services could be achieved when they are administratively unified.⁵

Experience at Coler Hospital, with some reservations, seems to verify the above statement. While the group worker must be identified as a social worker, it has not been fully demonstrated that in all instances this can best be achieved as part of the social work structure. Much depends upon the state of readiness of many medical social work departments to include a group work service in their structures. In addition, a successful group work program is contingent upon the quality of the medical social work service. Social work's generic base does not automatically lead to the conclusion that the field is ready for a generic method of operation. Much in the way of interpretation is needed.

At our hospital, group work and casework are drawn closely together in three areas of common interest: (1) individual treatment; (2) ward approach to group living problems; and (3) increasing community responsibility for patient care. Most of the literature in the social work field addresses itself to the first point, to group and casework activities on behalf of individual clients or patients. But the latter two common interests have given additional validity for the two methods to function under one administrative roof. The medical caseworkers are developing methods of adapting casework skill to the care of the long-term patient. In many cases, ward living is the only functioning world left for the patient. The caseworker is then called upon to help this patient make more effective use of his current hospital community experience. This common concern for patients' use of hospital group life has led caseworkers and group workers to deal with the problem of improving general ward and hospital life.

Too often the generic base of social work is viewed in narrow technical terms, *i.e.*, diagnostic skill, use of relationship, and

so on, but the social worker's concern for unmet basic human needs and for social change is an equally vital ingredient. This is a common interest that directs the skill of case and group workers toward the community in order to maintain the gains made by our patients. Again our experience indicates that this striving for societal preventive and treatment services can be more effectively accomplished when both disciplines function within a single administrative unit.

COMMUNITY RELATIONS

At Coler Hospital, we witness rehabilitation casualties every day—people who have painstakingly been helped in their struggle for physical and emotional survival only to meet frustration upon discharge to their communities. The gains made in the hospital are not maintained since there is a major gap existing and widening between the rapid development of rehabilitation service and the community's ability to absorb these patients. It has indeed been a privilege to work in a social service department which faces this challenge and charts a course of service that aims to close this gap. This department aims to (1) follow up selected discharged patients and thus help the community understand the problem of the disabled, and assume its responsibility for maintaining gains made in the hospital; (2) challenge existing restrictive public assistance procedures as well as try to liberalize current social security services to the disabled.

The group worker in our setting found himself increasingly preoccupied with patients' problems within the walls of this setting. This gravitational pull upon the group worker to limit activities to the hospital came from a variety of sources. First, there was the feeling that we should professionalize our service and establish a solid foundation within the hospital. While this was certainly valid, it seems that we rationalized constantly, that we were not

⁵ Kaiser, *op. cit.*

quite ready to venture forth into the community. Second, the hospital staff tended to view the community as some mysterious external entity. This staff became angry with this "strange" community when the discharged patients were not integrated. Gradually, the social work department has been helping the other disciplines see that the hospital is part of the community and should allocate some of its staff time to guaranteeing patient care in the community. The hospital, then, should become an effective community force.

The three disciplines which seemed to grasp more readily this essential point of community-hospital relations were the caseworker, rehabilitation counselor, and group worker. Group workers are now beginning to carry cases on the Home Care services as well as with discharged patients. As social workers they are beginning to knock on the doors of community agencies and to share the problems of the disabled person and his need for services. In addition, they are attempting to exploit program opportunities whereby the community can come in to the hospital and offer some service.

In the treatment-centered program we are beginning to view rehabilitation as a process that has an end as well as a beginning. In order to help a disabled person function to his maximum, within the limits of his disability, we must seek societal changes that will make this possible. The beginning body of literature describing group work in treatment centers ignores social problems as they affect the emotionally or physically handicapped person. Must professionalization lead to preoccupation with intra-agency matters? Ralph M. Kramer, in

a discussion of teamwork in the community,⁶ pleads for agencies to develop a community-relations policy. This kind of policy demands a beginning teamwork approach among community agencies.

In our setting, we were understandably preoccupied with securing a base for the establishment of group work. It was in the course of building this foundation that we came to realize that community contact is the lifeline of group work service. To justify our retreating within the walls of the hospital, we developed a host of professional rationalizations: "We must be satisfied with small gains . . . there's enough to do on each ward." Cold reality intervened and changed our point of view as discharged patients made their way back to our hospital, unable to resettle in the community. Regarding the integration problem of the hospital with the larger community, the group and caseworkers were not concerned with their methodological difference. We were involved in linking up the needs of particular disabled patients with the broader social problem of providing more adequate community services to the disabled.

If a rehabilitation program is to implement its total patient approach, the hospital and its interdisciplinary team should function as an effective and assertive force in the community. As is often stated, people, not diseases, are being treated. To affect people, we need to affect their social environment—at Coler Hospital we are striving to do so.

⁶"Dynamics of Teamwork in the Agency, Community, and Neighborhood," *Social Work*, Vol. 1, No. 3 (July 1956), pp. 56-62.

MEDICAL SOCIAL WORK SECTION

BY MARION KAHN

Some Observations on the Role of Religion in Illness

RELIGION IS AN item of social data on the face sheet of a medical chart that may easily be noted and forgotten. Perhaps not frequently enough is it incorporated into our total assessment of the patient, our attempt to understand the meaning to him of his illness, and our efforts to communicate this interpretation to physicians and others involved in his care. We need to remember that either in its less tangible aspect (a feeling, a source of comfort, a belief) or more tangibly (ritual, relationship with a clergyman) religion is often a resource.

The way a patient feels about his illness has come to be acknowledged by medical personnel as a fruitful area for exploration in helping to determine how an illness has come about and in what way health can most effectively be restored. Frequently

conditioning a person's adjustment to an illness is his particular religious orientation. Naturally, the significance of religion varies with each patient, according to his faith and the degree to which religious adherence and doctrine are important in his life. Unless the interrelation of the medical, social, and the religious is recognized, maximum effectiveness of none can be achieved. Religion needs to be considered not only by the social worker in the hospital, but is relevant in the lives of most clients. However, this paper will present the problem as it has been met in the medical setting. Let us consider some of the general areas in which the patient's religious orientation makes itself felt and look at a few illustrations in which religion has been directly related to the case-work process.

MARION KAHN, M.S., is on the teaching staff of the University of Wisconsin School of Medicine under whose auspices she serves as medical social consultant to The Monroe Clinic, Monroe, Wisconsin. This is an experimental teaching program for senior medical students serving preceptorships at The Clinic.

ILLNESS HEIGHTENS RELIGIOUS FEELINGS

When death seems imminent, religion may take on new and added significance for the dying person and his family. The irreligious man does not become an ardent believer; a sudden shift in attitude does

not necessarily take place; but often there is at least a greater preoccupation with religion and perhaps a reassessment of the place of religion in the life—and death—of the individual. This heightened religious feeling is not restricted only to the terminal patient and his relatives, nor must it be proportionate to the seriousness of the illness. For the majority of patients who find themselves in a hospital—and these are the people the medical social worker most often encounters—the very presence of an illness and the closeness to other sick people and to a hospital atmosphere may bring to mind associations with death. Who has not known someone who has died in a hospital? Thus we can assume that, to varying degrees, thoughts of death and a real or imagined threat of death may be present in the minds of many of the patients we meet.

What form do these thoughts take? Most religions teach their adherents to believe in the immortality of the soul, the presence of a life after death, the idea that life on earth is a trial period in preparation for the rewards of Heaven. With death even remotely imminent the skeptic may waver and fearfully ask himself, "What if after all there is a Judgment Day?" The person who has been a believer may ask himself, "Am I prepared for the hereafter?" This may involve a weighing of the good and evil in his life, an intense review of his past behavior, his relationships with other people, his good deeds, his transgressions. Facing possible death he may find comfort in the belief that his future is in the hands of a benevolent God or he may suffer severe anxiety that he will not measure up to the ideals or dictates of his faith. The medical social worker to whom religious content is presented in the course of interviews must evaluate its significance and understand that it may be a clue to inner or external resources—it may be a source of comfort, it may be a source of anxiety, tension, or confusion. Even if one considers religion as merely a psychological manifestation of

tension, a caseworker has to deal with it at least at first on the patient's level if it is to have meaning for him. Here as in every other aspect of casework practice she must meet the client where he is.

The mother of a teenager with advanced cancer often spoke of the major role religion played in their household and its great comfort during the long months Jane's condition was terminal. When she left the hospital each evening, she would try to reassure her daughter—and doubtless herself—by telling her she must not feel lonely because "Jesus will hold your hand." Later, after Jane's death, she had need to remark that Jane almost never missed Sunday school and was always a good girl. She expressed faith in a life after death and seemed pleased and comforted to think of Jane being "in a happier place." At the same time, however, she seemed to need reassurance that Jane would go to this "happier place," and spoke apprehensively of her clergyman's failure to visit Jane at the hospital or offer prayers for her salvation. Thus, in her religious faith, she found simultaneous comfort and fear; there is a Heaven, but could she be sure Jane was good enough to go?

Although one can think of a variety of causes for self-punishment by the parents of a sick child, one cannot disregard the religious motive. In Jane's mother we noted an active concern with the Biblical idea of the sins of the father being visited on the sons. Naturally, one would expect sadness and some withdrawal on the part of a mother watching her child die. But during the long terminal period, this mother virtually shrank from any potentially pleasurable experience or from any kindnesses extended to her because of a strong feeling that she had no right to be indulged, and that she had to suffer, to martyr herself, to insure her daughter's salvation. Her remarks over these months made it clear that along with any psychological motivation for this behavior was the strong influence of a deeply imbued Christian doctrine which

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told her that suffering on earth will be rewarded in Heaven. This attitude manifested itself in withdrawal from and often extreme hostility toward ward personnel who in any way attempted to make her comfortable during her long visits with Jane. This in turn bewildered and at times antagonized the staff. There is question as to whether very much usable support or help was given to this woman. At the same time one needs to recognize that certain religions teach that suffering has its rightful place in life and this concept may be in direct opposition to an individual's psychological motivation to protect himself against pain and to the caseworker's goal of relieving suffering.

In situations like this where the patient or relative may sometimes find reassurance or clarification in talks with a clergyman, the medical social worker can help arrange a meeting either with a hospital chaplain or the patient's own minister, priest, or rabbi. And with her special orientation and sensitivity to the interrelationship of the medical-social-emotional, she can serve effectively as liaison with the clergyman, especially the community clergyman, who may think less in the language of medicine and of illness in all its implications.

Instead of, or along with, being referred to a clergyman, the patient may find help in opportunities to "think aloud" about his religious concerns and perhaps about his past life. Here the social worker may serve the patient who has already found her to be an understanding, supportive person. However, this raises a problem. One of the first commandments of casework is not to be moralistic, not to stress right or wrong; we accept and attempt to understand behavior rather than judge it. Any judgments social work makes tend to be humanistic rather than moralistic. Yet the very matter of moral judgment may be troubling the sick person. Since good and evil are not essentially a part of the social worker's vocabulary, we must perhaps exert particular effort to be sure we understand the pa-

tient's language and appreciate that moral concepts may have a special and perhaps exaggerated import to the ill person. In our efforts to be nonjudgmental, we must not lose sight of the patient's vital concern with Judgment Day.

The precise role of social work here may need additional thought by practitioners in the field. The interplay of so many religious and nonreligious factors makes impossible any general statement applicable to all patients. However, the social worker must at least be sharply aware of the danger of adding to the patient's guilt, confusion, or anxiety by giving unreserved, automatic acceptance of behavior which the patient's religious standards deem unworthy. The social worker should not abandon her practice of being nonjudgmental, but she needs to consider that her particular professional yardstick for evaluation may not be versatile enough to measure all aspects of her client. She must distinguish between being nonjudgmental in her own approach and responding to the significance that moral judgment may have for the patient.

ADJUSTMENT TO DISABILITY

Not only when the threat of death is present are religious feelings involved. The case of Ronnie K, a 10-year-old boy, illustrates the way religious attitudes may play an integral part in adjustment to physical disability. Ronnie was in excellent health until his brother accidentally shot him and, though never in danger of losing his life, the boy was permanently and severely disabled. During his long hospitalization it became our task to guard against severe and permanent emotional disability as well. This boy's mother seemed haunted by feelings of responsibility and guilt for having failed to protect him from the accident. Initially she withdrew from anyone who tried to deal with the emotional and instead immersed her whole self in religion. Often one finds this kind of exaggerated dependence on religion as therapy. With a variety of so-

cial, emotional, and medical problems an individual may place undue emphasis on the curative powers of religion because this is a more socially acceptable and often impersonal form of help which one may seek through a more comfortable, less threatening medium than casework or psychiatric service.

This mother seemed to feel that no amount of personal indulgence could make up for her failure to protect him from the accident. It was as if, in her exaggerated need to compensate her son for his losses, man and God had to give unceasingly to the boy. With exaggerated zeal she insisted that Ronnie have daily visits from a clergyman and she often used her visits with Ronnie to discuss religion. (We should note that this family was quite religious and Ronnie had a substantial religious orientation both at home and at school. We cannot and should not attribute to the accident a new set of attitudes or values, but we can see a heightening and new significance to previously existing but less dominant behavior patterns.)

As Ronnie began to verbalize his feelings we became aware of a great religious preoccupation and discovered that nearly all behavior was appraised by Ronnie in terms of its sinfulness. Of the most trivial act he would ask, "Was that a sin?" Soon it was evident that two questions were troubling him: what grave sin had he committed to be punished in this way, and was it sinful for him to harbor antagonisms toward his brother who shot him? The avenues in which a caseworker may function with this family are myriad and need not be elaborated here. In these brief case presentations there is, of necessity, some oversimplification and what may seem an artificial separation between religious and emotional needs and responses. Of course, these are closely interrelated and what is important to our discussion is that this boy's attitudes toward his accident were inextricably woven into a complex pattern of religious concepts. In view of this and

with the hope of dovetailing and strengthening our services to the boy and his mother, we arranged for a conference with the clergyman who visited Ronnie. It seemed logical to assume that the clergyman was dealing in some way with this boy's feelings about sin and that a relationship had developed between them. Our talk revealed the dangers of generalizing about the role of a clergyman with a patient. Even though he saw Ronnie daily over a period of months, Reverend J could not recall at first which boy was Ronnie and knew little of the reason for his hospitalization. When we finally identified Ronnie, Reverend J explained that he offered daily prayers, but had no conversation with the boy or nearly any other patient because he believed a clergyman should remain remote, offer religion but never himself, and should discourage a parishioner from becoming dependent on an individual clergyman rather than on religion or the church. When we discussed Ronnie's preoccupation with sin, Reverend J replied that this little boy was obviously not sinful and he would tell him so, but essentially would continue to offer impersonal service.

Although this is undoubtedly an extreme situation, it makes the point that we cannot assume because daily visits are made by a clergyman that problems which seem at least partially of a religious nature are being dealt with. Here religious service consisted exclusively of a nonpersonalized religious ritual, the value of which this writer does not intend to malign or underestimate, but which left untouched the severely troubling problem which seemed at least partly within the realm of religion. Over a long period of time, much of Ronnie's and his mother's anxieties and the difficulties precipitated by the accident proved accessible to casework service, although the staff who were intimately involved in this case felt strongly that maximum help with social and emotional difficulties would ideally have come from a combination of pastoral counseling and casework service.

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A CASE OF SLOW RECOVERY

In direct contrast to Ronnie's situation is that of Mrs. E, a 32-year-old cardiac patient whose slow recovery led the medical staff to suspect that an emotional factor might be impeding medical progress. This prompted a referral to the medical social worker. Mrs. E participated in interviews in a friendly but superficial and guarded manner. After a time she could acknowledge that she was greatly troubled by difficulties of a religious nature, but she felt unable to reveal them to a social worker. She seemed reassured to learn that a clergyman could be invited to visit her. Before long she was having regular pastoral counseling and her heart condition soon began to improve. This sensitive clergyman was of unquestionable help emotionally and medically as well as spiritually. He kept Mrs. E's confidence as to the more intimate details of her problem, but shared with the caseworker that as a young girl Mrs. E had been divorced after a brief, unsuccessful marriage. Over the years this had weighed heavily on her conscience because divorce was contrary to the teachings of her church and especially because her present happy marriage constituted living in sin. Her second husband was far more religious than she had ever been and this illness precipitated all the feelings that had vaguely troubled her over the years—that she had brought sin upon her husband and that her illness might be punishment. Her recovery had doubtless been impeded by a feeling that she was meant to suffer and perhaps to die, to be taken from her husband so she could no longer "contaminate" him. In a series of visits with the clergyman Mrs. E was able to work through some of this guilt, and as these self-destructive impulses were reduced she became amenable to medical treatment and her health improved.

This case illustrates a co-operative relationship between clergyman and social worker where the pastoral counseling is clearly the strongest factor. Here the social worker served as a catalyst for a patient

virtually immobilized in her problem. Gradually, with relatively passive interviews, enough of a trusting relationship evolved to permit Mrs. E to admit to herself and eventually to the social worker that something troubled her severely. Yet this was not the place where she could comfortably share the problem or hope to resolve it. For the success of this case it was essential that the social worker recognize the limitations of her service and act as liaison between patient and clergyman. The real service here was to relinquish service, to recognize the importance of maintaining limited goals with the patient, and to acknowledge that the tools of another member of the helping team may be far more appropriate for the particular service this case demanded.

SEEKING CAUSES FOR ILLNESS

We have seen that religion sometimes affects adjustment to disability, recovery from illness, attitudes toward terminal illness and, as we shall see in our final illustration, it may relate also to etiology. Despite great strides in medical knowledge the doctor is often unable to tell the patient what caused his diabetes, epilepsy, leukemia, and so on. How natural for the patient to wonder, to look into his personal life for the answer to the inevitably troubling question: why did this happen to me, to my child, to my wife? As we have seen in the cases of Ronnie and Mrs. E, and as medical social workers have often found, patients sometimes see in illness a punishment for past indiscretions. Psychologically this is easily understood in terms of unresolved guilt or fulfillment of an unconscious wish for punishment; probably in everyone there is a sense of retribution. Etiologically, this may actually be true in the case of emotionally induced illness. Whether or not the illness is psychogenic in origin, retribution may be imagined by the patient seeking causes for an illness which limited medical knowledge makes it impossible for the physician to explain to the patient's complete satisfaction.

And here again the patient may question his own worth, be reminded of irreligious acts he has committed in his lifetime, or wonder if he has unknowingly sinned and caused a vengeful God to punish him with illness. Or he may question his faith in a God who permits this to happen to him or to a loved one.

The natural impulse to seek causes for an illness may be complicated by religious considerations. On one hand a placid acceptance of a serious or fatal illness as the will of God sometimes serves as an extremely positive, supportive factor in an adjustment to an illness. On the other hand, for a previously religious person who has felt he has lived an exemplary life, the onset of an illness may severely shake his faith in himself or in his God. As one newly diagnosed cancer patient said, "God is not good after all; or if God is good, I must be bad."

The father of a 3-year-old boy with leukemia was quite articulate about his feelings of why his son had to contract a fatal disease. Mr. D, a farmer and Sunday-school teacher, became quite impatient with friends and relatives who would repeatedly ask him what caused Jimmy to get leukemia. He would answer them somewhat indignantly with "We are not meant to know; it is simply an act of God." His impatience with these inquiries and his manner of reporting this in interviews led the caseworker to wonder how much Mr. D was trying to convince himself that he was not meant to know. With a suggestion from the worker that perhaps it was natural for people to wonder what caused an illness to develop in a particular person, Mr. D was able to verbalize his terrible conflict. As an extremely religious man he felt he had no right to question the will of God. He had intellectualized and rationalized at length and repeatedly told himself that God had chosen to take his son now in order to prevent him from growing up to a horrible future in which he might become a criminal or a sinner. His religious precepts had al-

ways dictated to him to live a good life, to trust in God, to accept whatever happened as "for the best," to think it presumptuous of any man to assert his will against the will of God. Now Mr. D found himself faced with an unexplainable personal tragedy which his religious beliefs told him to accept without question, but which his emotions vigorously protested. A man of considerable stability, Mr. D was ultimately able to come to terms with what first seemed to him an irreconcilable conflict. Support and clarification in interviews helped him to verbalize and understand some of his feelings about his son's incurable illness, eventually freed his feelings which he had tried to stifle and had felt he had no right to have, and focused on helping him accept his right to these feelings without excessive guilt. When religious attitudes came into play in the interviews, an attempt was made not to reduce their importance to Mr. D, but to acknowledge the conflict between them and his real though irrational reactions to the boy's diagnosis, and to help him utilize his religion as a source of support and strength.

Doubtless this conflict is not uncommon even though this man may have manifested a more literal adherence to fundamental Christian doctrine than we usually encounter. Here again, it was not the function of the caseworker to judge the religious belief of her patient or client, but it was her function and is her obligation to recognize the way in which an attitude toward the discovery of a fatal illness in a loved one may be colored by a religious orientation. These beliefs cannot be ignored, belittled, considered irrelevant, nor can they be dealt with intellectually. But they must be acknowledged, as is any other aspect of personality or any other personal resource, and appraised and dealt with to the extent that they affect acceptance of an illness.

SUMMARY AND CONCLUSIONS

We have seen that religion may play a major part in determining attitudes and

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behavior and while the handling of religious content must necessarily vary with the individual situation, it is nonetheless an important area for exploration by the medical social worker in evaluating the meaning of illness to an individual.

The social worker can serve effectively as liaison with the clergyman. She can help determine a patient's need for referral to a minister; she can clarify this with the patient; she can dovetail her own service with that of the clergyman; she can interpret to the minister the emotional and social aspects of illness in a general way or in relation to the specific patient; she can share responsibility with the clergyman as she does with other members of the helping team.

As our cases illustrate, medical social work must guard against ignoring religion. If religion brings peace to people, it cannot

be destroyed, belittled, or even ignored, regardless of the belief of the worker. She must instead utilize what may be a real source of contentment and strength. The practice of social work demands a self-discipline; we learn not to project our biases into our evaluation of a patient or client. Yet for the worker as much as for the client, a religious orientation may rarely be something we wish to or can examine carefully, logically, rationally. Still religion is something about which we often feel strongly, and inadvertently we may let our estimate of the importance of religion to the patient be influenced by its importance to ourselves. To be a caseworker and to be religious is neither necessary nor contradictory, but it is necessary that the caseworker respect religion and recognize its possible importance in the lives of the individuals with whom she deals.

PSYCHIATRIC SOCIAL WORK SECTION

BY DAVID HALLOWITZ AND ALBERT V. CUTTER

A Collaborative Diagnostic and Treatment Process with Parents

THIS PAPER PRESENTS an account of the involvement of parents in a therapeutic process for themselves, collaborating with the clinic in the treatment of their disturbed child. The rationale for this approach is that the interrelationships between each parent and the child; between the two together as an entity and the child; and between mother and father constitute the arena of conflict within which the child's disturbances originated and developed. There are several basic concepts and practices underlying this collaborative process:

1. Through a dynamic intake approach, consisting of one or more interviews, it has been found that parents gain a recognition of the emotional problems besetting them as individuals and as parents—problems that have contributed to the child's difficulties—and accept the clinic's offer of help to themselves as part of the treatment plan for the child. In fact, many parents actually seek this kind of help on a conscious or subconscious level.

DAVID HALLOWITZ, M.S.W., is assistant director (chief psychiatric social worker), and ALBERT V. CUTTER, M.D., is medical director of the Guidance Center of Buffalo, Buffalo, New York.

Because of their self-protective needs, the parents at first tend to stay at the level of the child's past and present symptomatic behavior. As the therapist¹ conveys his sympathy for them and his interest in them as well as the child, and as he feels them becoming more secure with him, he is able to ask: "Do you have any ideas yourselves as to what could be causing these difficulties in your child?" This is the turning point at which the therapist helps them explore various causative possibilities in their relationships with the child and with each other. Inevitably, he encounters subtle and overt resistances and defenses of varying degrees. The therapist expresses his understanding of their feelings of failure and guilt; their apprehension that the therapist will condemn them as bad parents; their angry feelings against him for opening up sensitive and painful areas. He emphasizes the reality stresses and strains in their life situation which would have been too much for most parents, as it was for them; their good qualities and positive contributions in the child's development; and the child's

¹ The term "therapist" rather than "worker" is used because in the Guidance Center of Buffalo psychiatrists also work therapeutically with parents.

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part in the breakdowns. As the parents become more secure with the therapist, they spontaneously bring forth material of vital diagnostic and treatment significance with respect to themselves.

2. During the diagnostic evaluation, the therapist in each weekly interview shares with them the findings that emerge from psychological testing and neuropsychiatric examination, doing so only after he has helped the parents to give their own evaluation of the child on such questions as the different and specific aspects of intellectual functioning; medical, neurological, and physical problems; and the degree of the child's emotional disturbance. More often than not, the evaluative thinking done by the parents coincides with the clinic's findings. Their reactions of disagreement are respected and gone into either from the standpoint of the psychological reasons for their inability to accept the reality and validity of the findings; or the possibility that their point of view may be valid, and that further diagnostic work through the treatment process and periodic diagnostic re-evaluations may be necessary.

PARENTS PARTICIPATE

3. As he works with them, the therapist constantly evaluates differentially the emotional health and strength of each parent as well as their relationship with one another. The intense anxiety and self-protective defenses which immediately confront the therapist can mislead him to think that one or both parents are psychiatrically disturbed and that the parental relationship is extremely weak. This situation then could cause the therapist to feel anxious, insecure, and overwhelmed himself, a feeling which would be sensed by the parents and make them even more anxious and defensive. Averting this pitfall by cutting through and helping the parents out of this overlay of initial anxiety enables the therapist diagnostically to see them more clearly. He may often discover that parents actually have basically good emotional health and

a good parental relationship; that the child's symptoms are not deep-rooted pathologically (checked by psychiatric evaluation); and that the parents can use the understandings gained to work out their problems with help from the therapist.

On the other hand, he may find evidence of neurotic or psychotic trends; or evidence of a character disorder with or without deceptive neurotic overtones, in one or both parents. Care must be taken to determine whether these symptoms of emotional disturbance in the parents are truly indicative of a psychiatric syndrome, or simply reactive to conflicts and breakdowns in the parental relationship. The marriage itself may have been quite weak to begin with. The parents may have been too immature in their own emotional development to assume the responsibilities of marriage and a family. Severe conflict between the parents and with the disturbed child may have arisen after, and in spite of, an earlier fairly good marital state. The resultant deficiencies of marital satisfactions may reactivate in the father or mother specific symptoms of emotional disturbance which, in childhood, were generated by conflicts with their own parents. In other words, a particular parent may have had a true psychopathological syndrome as a child. Reappearance of symptoms after many years may mean that, at the present time, they constitute a reactive disorder.

The parents participate in this evaluation of themselves. A history of psychiatric disturbance or marital breakdown, known either from reports obtained with their permission or on the basis of direct clinical evidence, is discussed with them. The therapist, at a timely point in the development of his relationship with them, raises the question of the possible need for psychiatric appraisal and treatment. Such service may be offered at the clinic or through referral to another psychiatric resource. Comparable evaluation is also made of severe breakdowns in the parental relationship. The therapist discusses fully the

question in effect, "Have you been in conflict with each other for so long that it would be impossible for you realistically to do much about this, or do you feel that there is some foundation to your marriage and that, with help, you can get hold of it and build upon it?" Referral for marital counseling may be considered with them. The alternative course of working with the parents at the clinic is weighed in terms of the specific nature of their problems and the child's, and whether the parents and child realistically are treatable.

4. The summation interview, in which the parents meet with the social worker, psychiatrist, and/or the clinical psychologist, constitutes a further intensive and dynamic involvement of the parents. Through their active participation, they are helped to crystallize the understanding gained up to this point and to bring into clearer focus the problems for which they and the child need help. Their relationship with the clinic as a whole becomes closer and stronger and adds to their growing feeling of security. At this juncture, planning decisions are made.

5. The foregoing principles and practices are applicable regardless of the various ways in which parents are seen. However, the treatment process with both parents together has been found to be possible in a large proportion of cases (64 percent of the treatment cases). Through this arrangement the parents are helped to bring out, in the controlled setting of the clinic, the feelings generated by intrafamilial relationship conflicts, to interact therapeutically with each other and the therapist, and to find ways, based on new understandings, of constructively dealing with these conflicts.

This interaction starts in the intake phase as the parents recall and remind each other of the numerous events in the child's life that bear upon the origins and later development of his emotional disturbance. They are helped to express their pent-up negative and angry feelings toward the child. As they move closer to looking at themselves,

they are especially in need of the therapist's help in overcoming inhibitions and resistances that set in. For example, if the mother is cautious or evasive in responding to the father's criticism, the therapist may help her say that she feels crushed by what he has said, or hurt because her husband betrayed her to the therapist, or quite angry in her own right at her husband, but afraid that she will lose control of herself if she expresses this feeling. The therapist must be sensitive to, and make use of, the subtle but very important forms of non-verbal communication on the part of the parents: the fearful cringing of a parent, the different emotions expressed in their eyes, the coldness and the hostility in their manner toward each other, their resentment toward the therapist, their leaning toward each other in mutual protection against the therapist from whom they at first anticipate judgmental criticism.

As parents come to grips and make headway with the problems in the parent-child relationship, they enter the even more difficult area of their relationship with each other. In some cases, separate interviews are necessary until they are ready to share their deeper feelings about each other.

The therapist strives to maintain balanced identifications with the parents. They may try to use him as a judge or compel him to take sides. The therapist takes the discussion to a deeper level in terms of the psychological reasons for the parents being so much at odds with each other, *e.g.*, their displacements and projections upon each other of their own individual feelings of inadequacy, insecurity, and frustration. Identifications also may tend to get out of balance from the direction of a parent to the therapist. In some cases, for example, the mother develops a strong transference to the male therapist, wishing that he were the husband and father. The therapist may comment, in the presence of the father, who senses the mother's dissatisfaction with him and identification with the therapist: "From what you say, it sounds as though

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you would like me to be in your home helping you." This kind of comment may lead to further opening up of feelings in the relationship between the parents, thereby bringing more into balance the three-way identifications in the treatment process.

The relationship with the therapist is the medium through which the parents work out their problems with each other and their child. Individually and collectively, they feel his genuine interest in them, and his acceptance and liking of them, despite their concepts of themselves as being failures and bad parents, and despite their having at times expressed anger and hostility against him. Their growing confidence in, and security with, the therapist enables them gradually to incorporate within themselves the understandings he has tried to impart.

6. Functioning as part of an integrated team, the therapist derives much of his security in a particular case, and much tangible help, from the close working together with the child's therapist, from the psychiatrist and clinical psychologist in the diagnostic evaluation of the child, from supervision, and from staff conferences.

CASE ILLUSTRATION

These basic concepts and practices are evident in the work with the parents of a 7-year-old schizophrenic boy.

Feeling completely lost and helpless, the parents desperately hoped that we would be able to take Paul for treatment and in time work a cure for him. They welcomed without protest or subtle resistance the opportunity to get help for themselves. The therapist explained that there was a great deal they could do to help themselves and the clinic team in relation to Paul. Initially these parents gained some understanding of the basis for Paul's placid, unemotional, uncomplaining, and undemanding temperament from infancy to the present, his inability to express warmth and affection for them, and his living mostly in fantasy. In earlier years, they

had regarded him proudly as a "little angel." They now realized that his temperament fitted in nicely with their troubled life situation at the time. The father was able to say: "I guess we wanted Paul to be that way."

The parents expressed their feelings of failure and guilt. The therapist throughout showed his genuine warmth and his acceptance of them. He would say that with such children as Paul, parents cannot help becoming confused, especially when their total life situation is causing them much worry. When the father said: "Maybe we really do not love Paul," the therapist replied in effect: "It is humanly impossible to have affectionate feelings for Paul when he is such a constant source of frustration and irritation. Moreover, you have had feelings of love for Paul but were too tied up with your own problem to convey them adequately to him."

Paul had been in a diagnostic-treatment process for one year with the psychiatrist before he was ready for full psychological testing. The parent-therapist met with the parents for weekly sessions. The psychiatrist participated in two of these sessions, and again in a summation interview following the psychological evaluation. The parents had already done a considerable amount of diagnostic thinking themselves. The parent-therapist and psychiatrist shared their findings with the parents. Observations of Paul's potential of high-average intelligence, his absence of brain damage and any gross or fine neurological impairment, and the severity and depth of his emotional disorder closely approximated ours. However, the more specific spelling out and confirmation of their fears about Paul's mental illness were quite upsetting to them. What gave them relief and hope was the genuine feeling of confidence expressed by the psychiatrist that by the help he and they were giving Paul, the psychotic process had already been arrested, and Paul was now on the road to betterment.

Intermittently the parents spontaneously tried to evaluate their own state of mental health and thereby gained important insights. The mother revealed that since Paul's birth she had had ulcerative colitis. The therapist helped her rediscover and bring forth the very upsetting and resentful feelings she had at that time in relation to her husband, feelings still currently active. The therapist weighed with the parents whether the mother needed individual intensive psychiatric treatment and held out the opportunity of psychiatric consultation with one of the clinic psychiatrists. The parents felt that she did not need this help. The father, whose functioning was relatively more normal than the mother's, became aware of the tight control he maintained over his feelings.

Working with them in regard to their relationships with Paul, the therapist talked with them about their reaching out to Paul and breaking through his walls of seclusion. Because Paul resisted or escaped into fantasy when they offered to play with him, the parents had previously given up in discouragement. The therapist explained that actually Paul had a deep need for them. The parents began to see that when they did not surrender to his negativism, Paul came around and participated with them in various activities. Once when the father took Paul for a car ride, ignoring his initial protests, Paul put his arm around his shoulder and said: "It has been such a long time since we have been together this way."

The parents needed help in expressing angry feelings to Paul. In addition to using specific incidents that occurred at home, something unexpected happened in one interview which the therapist also employed to advantage. Paul interrupted the interview two or three times. Annoyance and resentment showed in his parents' faces. Instead of acting on these feelings, they spoke in a quiet, restrained, and intellectual way to Paul. The therapist called their behavior to their attention, suggesting

that this kind of expression must be their manner with Paul in similar situations at home. Quite upset and flaring up angrily at the therapist, they argued that to let go of their angry feelings would cause Paul to go to pieces. The therapist helped them to see that it was the build-up of resentful feeling which Paul sensed, and their consequent explosive outbursts that were harmful to him. The therapist agreed when they said that in certain situations Paul's actions were beyond his control. He helped them see the difference between Paul's controlling and uncontrollable behavior.

In regard to the parental relationship, they increasingly expressed their resentful feelings to each other. The mother told her husband that he was like Paul in many ways. He volunteered to wash the dishes so that he could be off by himself rather than help her with Paul. She admitted being upset and angry when her husband had to go to professional meetings leaving her with the whole burden of Paul. She expressed her unhappiness at not being settled in a home of their own after all their years of marriage and their not having thought through together where they were going in life. The father responded actively, expressing some of his resentments to mother. At a later point the mother once observed with feeling that it was so good when she and her husband could talk with each other and thrash things out; otherwise she did not know what he was thinking and feeling. She also told him directly that she wished he would "crack the whip" with her and assert himself, because when she got angry at him and he walked off silently, she felt very upset and guilty inside.

The parents also got angry with the therapist at times. For example, the parents once flared up at the therapist: "Why do we have to do all the work?" The therapist commented that they were feeling frustrated, discouraged, and angry at him and the clinic for the long time it was

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taking to help Paul, despite their hard efforts.

The parents gained understanding of the somatic effects brought on by their suppression of angry feelings. At one point, for example, the mother pointed out to her husband: "... and that's why you get these headaches." The therapist interjected, speaking to the mother: "And that's why, in addition to the physical causes, you have had ulcerative colitis." The therapist helped the parents examine the reasons for their having had difficulty in expressing their negative and resentful feelings to each other. The mother asked her husband if he were afraid that she would become ill again. He did not think so but that it had more to do with his own upbringing. The parents proceeded to discuss their respective childhoods in this regard.

Thus relationships in this family began to move in a healthy direction and Paul's progress in treatment paralleled this movement.

USE OF RELATIONSHIP

In this case, the therapist encountered serious problems in the parent-child and parental relationship which resulted in marked lacks in the parents' affectional reaching-out to Paul, and a build-up of resentful feelings toward him, all of which must have felt like rejection to him. There were several contributing factors: the physical absence of the mother because of illness in the first two years of Paul's life; the psychiatric disturbance this illness represented within her; the emotional absence of both parents because of their pre-occupations with themselves; the mother's basic unhappiness at her separation from the security of her own family and her inadequate compensation in the relationship with her husband; the tight control the parents kept over their own feelings; and their anxiety, insecurity, and confusion in relation to Paul.

Generally, the contributing factors to

emotional disturbance are quite different in kind, but they also have the effect of producing the feeling within the child that his parents do not love him or do not love him enough. The parents may be weak and ineffectual in their discipline. This inconsistency gives rise to the vicious cycle beginning with anxiety in the child; followed by additional obstreperous behavior. The child interprets the parents' mounting resentment as further proof of rejection, resorting to greater acting-out behavior against them, and so on. The impetus for this vicious cycle might easily be the unawareness on the part of the parents of their shifting their attention excessively to new children coming into the family. On the other hand, in such situations, the slighted child may resort to a pattern of withdrawal instead of aggressive acting-out behavior. In cases of severe conflict and breakdown in the relationship between the parents, they are usually so bitter, unhappy, and emotionally drained that they cannot gratify the child's need for their love. Often they take out on the child the frustrations and resentments they feel toward one another or use the child as the battleground for their conflicts.

The therapist must be ever on the alert to help parents become aware of, understand, and constructively deal with the specific factors, whatever they may be, in the parent-child and parental relationships that contribute to the child's feelings of rejection, insecurity and unhappiness, and the particular forms these feelings have taken in finding an outlet.

The therapist's relationship with the parents is the key to the helping process. A vital ingredient is the high degree of self-awareness the therapist must have. He can readily be swept into feelings of discouragement and hopelessness by a most unfavorable external symptomatic picture at the point of intake, by definite diagnostic findings of severe psychopathology in one or both parents, by comparable findings of severe conflict and breakdown in the

parental relationship. He can too readily jump to the conclusion that the parents are "sick" or that they are basically rejecting of the child. All the symptoms and problems must be carefully, differentially, and realistically evaluated. Often, if the therapist maintains his own security and equilibrium, cuts through the symptomatic overlay, helps the parents over their defensiveness with him, and ultimately gets to the people themselves, he finds that the presenting picture is not as bleak and forbidding as it first appeared; that within

limits the disturbed parents can work on some of the relationship problems in the family; that most parents are not really rejecting of their child but have capacities for love and acceptance of him that have not had much opportunity for expression; and that there are hidden capacities in many parents for self-understanding and change. Gaining a hopeful and confident feeling about parents, provided that it is a diagnostically sound one, is a vital, intangible dynamic determinant of the therapist's effectiveness.

A social anthropologist examines

The Psychiatric Hospital as a Small Society

By WILLIAM CAUDILL

Because in-patient therapy does not take place in a vacuum, an understanding of the emotional interaction within the social microcosm of the mental hospital is vital to effective therapy and administration. As a resident observer, Dr. Caudill studied both patients and personnel on the wards, at staff meetings, through therapy-hour notes, and in interviews using an original "picture interpretation" technique. The re-

sult is a detailed, comprehensive analysis of interrelations within the overt formal and informal structure of the hospital, and within its covert emotional structure. In addition, his unique reconstruction of the events leading to a major patient disturbance during his stay at the hospital is an invaluable guide to all hospital administrators. \$6.50

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SCHOOL SOCIAL WORK SECTION

BY DOLLIE R. WALKER

Use of the Knowledge of the Casework Process in Collaboration with School Personnel

A LITTLE MORE than a year ago, a group of social workers in the Department of Education, Baltimore, Maryland, selected for study that aspect of school social work which involves collaboration between social worker, teacher, and principal on behalf of a child with school problems. These social workers were keenly aware of the principal and teacher as school people who often held the key that opened or closed the door through which the social work service was given. In several sessions in an in-service training program, concentrated attention was given by the group to finding ways of achieving a more effective partnership between educators and social workers in a school setting.

The group immediately acknowledged that the success of the interdisciplinary approach in helping a child with school problems hinges on the relationship existing between the various disciplines. There was agreement that this relationship must be founded on mutual trust and respect. In addition, we heed that this relationship can be furthered by the human warmth, the knowledge and skills a social worker brings

to the total job of collaboration with school people in offering a casework service to the troubled child. Over-all collaboration was seen, therefore, as a continuous process, but collaboration on behalf of a child was seen as a process with a definite beginning, middle, and end.

In this paper I shall describe, first, what the group came to in identifying the function of the school social worker and in defining the term collaboration. Second, I shall state briefly what was agreed upon as administrative responsibility in facilitating this service. Third, I shall point out and illustrate by case material the phases¹ in the collaboration process identified by the group and present a structured way for a worker to collaborate in a school, as that plan evolved in the course of the group sessions.

It was agreed that the central function of the school social worker is that of providing casework service for the child with problems interfering with his adjustment in school. The child, too, has responsibilities. But often he needs help in doing such things as getting himself to school and in using the experience there for his educational growth and development. By using

DOLLIE R. WALKER, M.S.W., is specialist in School Social Work, Division of Special Services, Department of Education, Baltimore, Maryland.

¹ As in a casework process—beginning, middle, and ending.

his casework skill, the worker establishes a co-operative relationship between the child, his parents, and the personnel of the school. By using the appropriate resources within and outside the Department of Education, the worker helps the child to take responsibility that is appropriately his for the problem, helps the school personnel to individualize the child, and assists the parents to share the responsibility for the child's change.

In dealing with collaboration as a concept, the group limited its meaning to that of the co-operative efforts of the social worker, the teacher, and the principal. Out of this discussion came a clearer understanding and definition of the important function each must fulfill in helping the troubled child to come to terms with the demands and expectations of school. In the process of collaboration, the worker was seen not only as the "helping person" to the child but also as the means for assisting those from other disciplines² in the school to understand and involve themselves in the child's situation.

Considerable thought was given by the group to the responsibilities carried by the administration, located in the Division of Special Services of the Department of Education, in facilitating the social work service offered to the schools. Part of that administrative responsibility is acquainting the school principals with the service as defined and given by the Division of Special Services through social workers. The division could and should say what the service consisted of and how it should be offered. It should be held accountable for the standards of performance and quality of service rendered. The principal should be given the opportunity to say whether or not the service is wanted. He should know that to receive it, private interviewing space should be provided and that opportunity should be given for the worker, principal, teacher, and other school personnel to become in-

volved (in collaboration) in their efforts to help the child. The agreement between the division and principal to offer social work services should be flexible enough to meet the necessary variations in individual schools.

The worker starting in any school should "begin" with the principal since he is the leader and co-ordinator of all personnel and services in the school. It was accepted that the worker's attitude, old and current, toward school and authority needed to be examined as he sought to become an integral part of school. The social worker brings positive and negative feelings to the collaborative process, hope or expectation, projection and blame toward school; defensiveness toward service. The kinds of feelings he might meet in the principal were explored: doubt, uncertainty, and ambivalence, perhaps, about wanting service. It was agreed that it is the responsibility of the worker to help the principal to come to terms with and find himself in relationship to the service. This means the worker should value himself as a professional person and be clear about the way the service entrusted to him is offered. He should not deny any problem in working with a principal, but deal appropriately with it. He must face squarely the feelings (good or bad) that are characteristically inherent in any psychological beginning, as he begins his work with the school's administrator.

FIRST PHASE OF COLLABORATION

The following excerpts from a case record were used to show the beginning process of collaborating with a vice principal. The month is September. The worker is now in the school and has been introduced by the principal to the vice principal with whom he is to work.

The vice principal was polite and very business-like in his manner. He looked down at his desk on which he had spread all of the records and related material concerning the six children who had

² Teacher, principal, nurse, doctor, counselor, psychologist.

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been carried over for division service for the school term ending in June. He told me that he was in a hurry that morning, but he was sure I knew what I needed to do with the material, and that he was glad to see me.

Even though Mr. Henry's words were polite, I sensed his feeling against my expecting him to be available to talk with me. I told him that I was new in the school and that I wanted to be of help to the children in his school who were having problems in using the school's program. I would need to talk with him first since the principal had said he would work with me. Mr. Henry was still too busy to see me that day even though I was prompt for my appointment with him, and he did not tell me when he might be able to talk with me later. During the entire time I talked with him, I remained standing, although I was sure that usually Mr. Henry was very polite. I looked straight at him, smiled, and asked, "Mr. Henry, you don't want me here do you?" Mr. Henry, who had been seated while I was standing, stood up at this point, fumbled with the papers on his desk, and as I looked around at the empty chair in the room, he gestured for me to have a seat.

When he had composed himself a little and I had told him of my willingness to discuss with him the feelings he had against my being there, he said he did have a question as to the help that I might offer. He poured out a stream of hostility against the division and the feeble service he felt it had given. Some of Mr. Henry's feelings sounded as though they might be justified, some not. At any rate, I expressed frankly my inability to change what had passed. I could offer no guarantee for his satisfaction; I could only try, but he was not obliged to have me in his school. I was sure, from the appearance of the building and the care with which it was kept, as well as the apparent orderliness of its operation, that he was using many of the services that were available to him in the Department of Education. If he refuses this one service, I was sure it was within his right. Mr. Henry seemed

quite surprised to hear this. He had thought he had to have me there whether he wanted me or not. He seemed a little more relaxed and told me he would be willing to try to work with the division. He then showed me a very attractive office which was to be mine. I laughingly questioned what he expected me to do with the records that he spread out on my desk. He looked at them and started to pile them up as he said, "Today we can get acquainted. We don't really have to do all of this."

Discussion of this material elicited the following points:

In this beginning, the worker was able to take responsibility for the feeling he and his function brought about. This worker was not lacking in intuitiveness. He dealt with Mr. Henry's doubt and uncertainty and ambivalent feeling about wanting his help with the problems in school. "Mr. Henry, you don't want me here," was a way to concretize the problem so as to break up the totality of feeling.

The worker was able to bear and receive the hostile feeling of Mr. Henry and yet to respect him as an individual. He knew that it is usual for a person who is making a beginning with another discipline to tighten up the will of organization so that it is difficult to become involved. There may be fear of what the other person will bring, fear of change of self, and fear of loss of control. Therefore, a pulling away is understandable. However, the caseworker does not force service. Mr. Henry had a choice to accept or reject the worker and his offer to help the children in his school. Mr. Henry was helped to have a part in this beginning. Likewise, the worker had a part in the beginning, too. The worker knew that he would not feel rejected as a person if the principal did not want his services. Once a principal expresses readiness for the service, the social worker relies on him to help the teacher who may also have doubts and reservation about school social work.

The group concerned itself next with the work with the teacher. It was recognized

that the worker establishes a continuing professional relationship with the teacher. This relationship recognizes the primary responsibility of the teacher for the child in school, in the group, and the child as an individual. A good teacher feels that it is her responsibility to refer for specialized help a child who seems unable to use effectively the teacher-pupil relationship and the classroom situation for his own learning. With such a child the teacher and social worker have a unity of purpose, namely, that of helping the child to become educated. Their functions and responsibilities are different but together they enrich the contribution made by each toward reaching a common goal. There was general agreement that the child is helped most effectively when all professional people concerned in the school share an established way of working together.

It was therefore recommended that regular planned conferences be used as the basis for collaboration between the professional people concerned in helping a child to change. To enter a situation only at the point of a crisis was considered poor practice. The following excerpts from case material were used to show a constructive beginning made with a teacher.

11-23-55: Conference Among Teacher, Vice Principal, and Social Worker

Miss Jacobs, the teacher, was out of breath as she came in today with educational records in her hand. She seemed quite irritated with 7-year-old Tony Cain. He had been spitting on the other children, pasting paper on his face, and doing anything he wanted to do. She believed that he enjoyed being in school every moment, but he created so many problems for her and other children that they were ready to let him have the classroom by himself. He sounded like a little terror. I could hardly imagine that he was only in the first grade. On the other hand, I knew that a first-grade child could create this much disturbance if he really decided he wanted to forget about the others involved. I tried to determine

whether Miss Jacobs felt that Tony was capable of doing what she expected of him. On the one hand, she agreed that he was capable, and on the other she gave evidence of a doubt of Tony's ability to do something different even if he had the will to do so. I tried to find out whether she felt she could tolerate him in the class for two or three more weeks while we evaluated what kind of help might be available to him or what help he might be able to use. She did not know. She thought she could try.

I questioned Mr. Henry, the vice principal, who was taking a very active part in the discussion about his knowledge of Tony's behavior during kindergarten, and asked whether he thought Tony would need to be suspended from school while the problem was evaluated. Mr. Henry did not believe so, and Miss Jacobs seemed shocked at the thought of suspending him. Certainly she did not want to do this. She could keep him in the class a while longer. After all, Mrs. Smith, the previous teacher, had kept him a whole year. I thought Miss Jacobs might have some feeling about the fact that Mrs. Smith had been able to do more with Tony than she. Mr. Henry said quite openly that Mrs. Smith, a much more mature woman who had reared children of her own and worked with kindergarten children for a long time, dealt differently with Tony and his problems, but assured Miss Jacobs that Tony had been a problem from the beginning for Mrs. Smith as well. We talked about the steps the school had taken to help Tony and how these had failed. At the end of quite a lengthy conference, Miss Jacobs seemed more relaxed than before and stated that she would try to engage Tony's interest in whatever way she could while we evaluated the problem. His mother seemed to need a great deal of help, too. Miss Jacobs had talked with the mother. She wanted help from the school in helping Tony. She believed he would "grow out of it," because her oldest son, Bill, had also been a problem when he was in kindergarten and first grade. It was agreed that we would get together again in three weeks after I had

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explored the situation further. I would see Tony and his parents. Miss Jacobs told me his parents were separated.

The group discussed this material in the following way:

In such a beginning of collaboration on behalf of a child, the educational record (the referral blank) has value. Filling out this form can be a dynamic for helping a teacher to get a sense of her own need to be involved with the social worker in helping the child. In this conference there was engagement of worker and school personnel at the time of referral. The social worker found out what had been done, what the school's concern was, and what the school expected. The school learned what the school social worker planned to do and what she expected of them.

In this conference each discipline had an opportunity to express an opinion, ask questions, hear others, pool thinking, and reach an agreement relative to a referral. The conference offered both principal and teacher a chance to present the problem as they saw it and offer an opinion that might be of help. The turning point was the teacher's expressed willingness to continue to try to discover what this child was like and whether he could be helped. Together the teacher, principal, and social worker decided that time should be allowed for the social worker to explore the child's problem and get a clearer picture of his living situation. The social worker would try to evaluate the child's willingness to use casework help as well as the willingness of the parent to become involved in the resolution of the school problem. The three-week time limit set by the worker to get back to the teacher was supportive. It gave focus and purpose for the second conference.

MIDDLE PHASE OF THE PROCESS

This brought us to a consideration of the second phase of the collaborative process, the middle, where the school people will decide together the how and why in the

situation. Will they go on and who will do what? The following summarized illustration was used to clarify the middle phase of the helping process.

12-17-55: Conference with Teacher and Vice Principal

On this date we got together again to evaluate what I thought about Tony and his home situation and what might be helpful to him. I agreed with Miss Jacobs that he needed help. He was a very immature child whose parents had recently separated. Mother worked and was in such a hurry to get out in the mornings that Tony was not even allowed to dress himself. I could not be certain of the extent to which I could help him begin to fit in better in his class. So much depended on what each of us could do and most of all on what Tony did. Mrs. Cain, the mother, had her own problems, as well as Tony's to be concerned about, but I believed I could count on her co-operation. She had agreed to get up earlier to let Tony begin to take responsibility in starting to dress himself and to hold him to being more of a boy and less a baby. Miss Jacobs was a little skeptical about whether Tony could change enough to remain with his class. At the end of the discussion, she thought he probably had a lot to cope with at home, and she would try to be more patient with him. Perhaps she could help him by making a distinct effort to be clear and simple in her instructions to him, and in holding him responsible for doing the things he seemed capable of doing. I thought this could be very helpful to him, and I realized and appreciated the effort she was putting into helping this boy. It was agreed that I would see Tony each week for three weeks and Mrs. Cain, the mother, again today. The teacher and I would evaluate Tony's situation again on January 4.

1-11-56: Brief Discussion with Teacher and Vice Principal

I told them that I had shared with Mrs. Cain, Tony's mother, what Miss

Jacobs and I had agreed on when we discussed Tony this morning, that he was making a concerted effort to improve in school. Miss Jacobs felt that he was intelligent enough to learn, but his nervousness, anxiety, and desire to be a baby in order to secure a great deal of attention had kept him from learning. I thought it could be expected that Tony might for a while sustain his efforts to improve, and then lapse into periods of wanting to be a baby.

Miss Jacobs saw some disciplining of himself on Tony's part already and some improvement; she had not had to speak to him in over a week. Two weeks later, however, he had experienced a very "bad day"—did the same things he was doing at first. I stated that Tony had bragged to me in a complaining tone, "She never says anything to me now." Miss Jacobs became very thoughtful and said slowly that perhaps she could begin to give him a different kind of attention. She could see how he might feel about no longer being the center of attraction.

Group discussion made such points as those which follow:

The worker realized that she must not usurp the teacher's function or her relationship with the child. When a worker becomes a teacher (or vice versa), she fails the child in her helping role. The worker needs to know her own job and seek to engage the teacher in what the teacher sees as hers.

This material indicates that each person involved in helping the child has to know his role and how he functions within his or her role. Teacher, principal, and worker all were together in their planning. They had to be working together in order to know what is different in the contribution that each brought to the conference and planning. This worker knew that if she attempted to work alone to help this child, she would become an island rather than an integral part of school. Miss Jacobs, the teacher, was aware of some of Tony's needs but was left to find ways of meeting them in her own classroom. Her skepticism

about whether Tony could change is natural. She showed some resistance and uncertainty about her own involvement in his change. The social worker, in order to help the teacher, needs to stay with her on a feeling level with what she brings to the conference.

This sustaining period that characterizes the middle part of the collaborative process can mean desperate hours for the other disciplines. The child may get worse. What can the social worker do? He works with an awareness that this is a testing period for the child during which the teacher or principal committed to the goal of helping the child really becomes involved with him (the worker) at a new depth.

THE ENDING

The last phase of the process, the ending, was also examined critically. The group agreed that in preparation for ending or terminating casework service with a particular child, the original problem is reviewed with the school personnel and the situation re-evaluated. Fear may characterize this phase in the process for the client and for the teacher and social worker, too. There may be fear of separation, fear of going on alone without the help of the others, fear of the new, and kind of hanging on to the old. The ending may also be colored with anxiety, impatience to end and to get on to the new. Just as the caseworker needs to be with the client in the ending phase to try to help him trust that he can meet what is to come and sustain himself, in the same way he can use this same knowledge and skill in ending with school personnel.

It was reported to the group that the end with Tony and his mother and teacher came when they realized that the problem was resolved to the point where they no longer needed the worker's help. The worker set a two-week time limit within which Tony and his teacher could accept their readiness to go on without her.

Miss Jacobs, the teacher, finally said she would have to trust this change she

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saw in Tony. Also, it was the worker who reassured the teacher that change might not be permanent but that she would be standing by for a reopening of service to Tony if it was needed. Together the principal, teacher, and worker decided to end.

A STRUCTURE FOR COLLABORATION

In summary, as a result of the foregoing material, the group decided that, in collaborating with school personnel (teacher and principal) in the interest of a troubled child, the worker in any school system could be more effective if he adhered to the following structure.

Procedures and Methods in Collaborating with School Personnel

A. Referral

1. The administration wants to know the school's needs for school social work service and asks that all situations needing the service be referred to the school social worker.

2. When a teacher or other faculty member wishes to refer a child, the referring person, principal, and school social worker should confer (all together, or worker with each separately) to consider the problem. At this time it is helpful to have a referral form filled out by the teacher and made available to the school social worker.

3. The planned referral conference.

- a. In such a conference the worker is able to learn what the school is expecting and whether the service can attempt to meet these expectations.

- b. In the conference, it is not only valuable but essential that the worker be given the benefit of the school's knowledge of the child's problem and his situation; including an understanding of what the school has done already to help both child and parent, and any ideas the school may have about the child's need and abilities.

- c. Included in the conference should be joint study of the data available in the cumulative record.

- d. Those conferring should reach mutual agreement as to whether this problem

calls for further exploration by the worker.

- e. Conference planning should allow the worker a period of time for exploration and for evaluating whether the child and parent can and will use help. A specified time for a second conference should be set for the worker and school to reconsider the needs of the case on the basis of the worker's and teacher's findings.

B. Continued work together as a team in behalf of the child

1. Further planning takes place in the second joint conference when members of the team share what their experiences have been in relation to the child since referral.

2. On the basis of this, a decision is made as to how each member of team will carry out his role and responsibility. It is very important that roles be clearly defined, understood, and agreed upon.

3. There should be a time limit set for everyone for carrying out whatever is decided. Conference should be arranged to evaluate what has happened and to decide on further focus of work. The report-card period (2½ months) seems to be a good block of time.

C. Termination of service

1. The decision to terminate service to a child, whether he has improved or not, is a joint one. It is estimated that a child who is able to use help should do so within a year or less. If not, the value of continuing for a longer period should be carefully weighed.

2. This "ending" conference includes a review of the original referral and re-evaluation of the school situation.

This in-service training group of school social workers emphasized repeatedly that the basic responsibility for troubled children with school problems rests with educators. The efforts of school social workers, like those of other disciplines in the school system, must therefore be oriented toward the support and implementation of the educator's purpose.

BY HARRIS K. GOLDSTEIN

Some Task-Originated Requirements Found in Student Casework Practice

THE STUDY REPORTED in this paper attempted to learn more about what was responsible for the variable performance observed among even competent caseworkers. Observers of social work practice are generally in agreement that even competent caseworkers do some tasks well and other tasks poorly. This phenomenon is sharply highlighted in the evaluations of student field practice made at the end of each semester. As late as the end of the fourth semester, though student selection, education, and training have each done their part, evaluative statements of supervisors indicate that some students perform some tasks better than other tasks.

These variations in the adequacy of performance of tasks, by any one student or by groups of students, usually have been considered as associated with something in the student. The usual efforts to overcome this variation have thus been focused on improving the selection of individuals who

come into the profession, providing better training, or both. These approaches implicitly assume that different tasks make similar demands on the student, and if the student cannot carry out some tasks, a remedy within the person has been sought.

On the other hand, at least some of the administrative and training procedures of the profession imply that tasks themselves are different. When it is not possible to make a better selection of persons coming into a position or to improve their skills with training, assignments are often made administratively to tasks which it is seen that personnel *can* do. Such a procedure implies that tasks themselves are different, that there is enough variation among tasks so that certain ones can be carried out by any worker, however limited he may be. Certain tasks are among the first commonly assigned to students, implying that some tasks are different in being easier to learn, or provide a basis for learning other tasks, and so on.

Experiences in other fields tend to support this implication that social work tasks are different from each other in terms of requirements of the student. Tasks in other fields have been found different in what

HARRIS K. GOLDSTEIN, D.S.W., is assistant professor at the George Warren Brown School of Social Work. This paper is based on a study performed for a doctoral dissertation at the George Warren Brown School of Social Work in 1957.

Task-Originated Requirements

they require, either in tools or in operations that must be carried out. In engineering, for example, tasks have been found to differ in what they require of the engineer. Some tasks in engineering are known to require relatively more or less perceiving of spatial relationships, others require different degrees of abstract reasoning, numerical skills, and so forth, if the tasks are to be completed successfully.¹

The writer attempted to learn in this study if casework tasks also had different requirements of students. The existence of the usual variations within students was granted but the assumption was made that "somethings" present in the tasks also influenced performance.² Since these "somethings" were considered to be requirements of the student by the task, or Task-Originated Requirements, they were called TOR's.³

The word "task" as used above and in the study reported in the following material was given a specific meaning. It was used to designate "pieces of doing" as described in supervisors' evaluative statements of student field practice performance. Examples of such pieces of doing are the following (pieces of doing in each statement are italicized): "*She focuses interviews poorly*"; "*He uses community resources discriminately*"; "*Her recording is kept up to date*"; "*He is slow in integrating theory and practice*." Though such pieces of doing or tasks varied in scope, all represented activities rather than traits or goals sought.

¹ The fact that these requirements of tasks are for something in the student does not contradict the concept that the requirement is set by the task, and therefore can be conceived of as associated with something in the task.

² These "somethings" were not requirements for visible activity but were constructs or theoretical explanations for influences on performance from something within tasks.

³ This symbol rather than some everyday word is used for the concept of task-originated requirement partly for purposes of brevity but largely to eliminate the problem of surplus meaning associated with everyday words.

POTENTIAL GAINS FROM KNOWLEDGE OF TOR'S

Knowledge that there were Task-Originated Requirements, or TOR's, and specific knowledge of their nature were considered to have many applications for the assignment of personnel, for the evaluation of performance, for on-the-job training, and for social work education.

If TOR's influencing performance in various tasks were known, workers could be assigned to tasks with TOR's similar to those tasks they did in superior fashion. Tasks predominantly influenced by each TOR for each of the casework specialties might be found and then these tasks could serve as a simple, economical, and uniform basis for evaluative standards. Once TOR's were known, in-service and student training could be aimed at increasing skills in key tasks predominantly influenced by each TOR. Educators could decide which key tasks (representing TOR's) should be taught first. Criteria for student selection could emerge from the association of certain personal characteristics of students and adequate performance of key tasks representative of TOR's.

HYPOTHESES TESTED AND ASSUMPTIONS MADE

The basic hypotheses of this study were based on the administrative and training procedures mentioned in the analogies above and on the observations of variations in task performance noted earlier. These hypotheses were as follows: Task-Originated Requirements (TOR's) were few; their nature was describable.

To test these hypotheses certain assumptions were made: first, if TOR's were essential for completion of social casework tasks, TOR's must influence the adequacy with which each task was performed; second, tasks with similar requirements would be carried out with similar degrees of adequacy, when all other influences on performance from sources outside tasks were kept constant; and third, some inferences

about the nature of TOR's could be obtained from the characteristics common to those tasks carried out with similar degrees of adequacy.

METHODOLOGY

Study was directed at tasks performed by casework students rather than practitioners with the aim that findings would have meaning for education as well as practice. Tasks were represented by statements from 29 supervisors' evaluations of 60 students, who had finished their third semester of casework field practice. These statements, 3,600 in number, were classified into 17 classifications based on 6 discrete and observable entities mentioned in the supervisors' statements and the content of material studied.⁴ The 6 discrete and observable entities mentioned in the statements were student, client, agency, supervisor, community, and colleagues of the student. Statements clearly separated the activity of the student from the activity of the client, and both of these from the activity of the supervisor, agency, and so on. Statements, with few exceptions, also indicated who was the subject and who was the object of activity. These two kinds of activities, being the subject of activity, or "acting on," and being the object of activity, or "reacting to" for each of the 6 entities above provided 10 classifications of tasks as follows:⁵

1. Student acts on the client.
2. Student reacts to the client.
3. Student reacts to agency policy, program, etc.

⁴ Reliability of classification was tested by computing the phi coefficient between those statements classified in the same class and other classes on subsequent trials. Phi coefficients for intrasubjective reliability for each classification ranged from .71 to .91; phi coefficients for intersubjective reliability between experienced social workers ranged from .67 to .91.

⁵ This system theoretically provided a total of 12 classifications. However, no statements were found in evaluations regarding the students' reaction to community resources, or the student acting on the agency.

4. Student acts on student (self).
5. Student acts on and reacts to others.
6. Student acts on supervisor.
7. Student reacts to supervisor.
8. Student acts on community resources.
9. Student reacts to student (self).
10. Student interacts with client (relationship).

The content of material in the supervisors' statements yielded seven other classifications:⁶

11. Student reacts to casework theory.
12. Student acts in an organizing fashion on work.
13. Student acts on and reacts to recording.
14. Student acts on and reacts to written material other than recording.
15. Student accepts the client.
16. Student reacts to social work values.
17. Student integrates theory and practice.

This particular classification system was used for two reasons: (1) classification on the basis of observable entities improved the reliability of classification; (2) this system also reduced the likelihood that analysis would be based on and influenced by supervisors' common ways of conceptualizing practice in that it cut across the usual categories of social work thought, such as study, diagnosis, and treatment.

Performance of each student in each classification was rated as high or low by the writer.⁷ The similarities and differences among the performances of the student group in the various classifications of tasks (as reflected in supervisors' statements) were noted, and from analysis of these similarities and differences, the influences (Task-Originated Requirements, or TOR's) considered responsible for variation in task

⁶ Statements in Classification 15 were found to be different from Classifications 1 and 2 in adequacy of performance of students studied, and were classified separately on this basis as well as on the basis of content.

⁷ Reliability of rating between experienced social workers ranged from .78 to .98 as measured by the phi coefficient, for the various classifications.

Task-Originated Requirements

performance were isolated and described.⁸ To provide assurance that influences from tasks (TOR's) rather than influences within students were being studied, the same student group was studied on all tasks, and thus served as a "standard" student or measuring instrument for similarities and differences in task performance.⁹

FINDINGS AND CONCLUSIONS

Six independent Task-Originated Requirements were found but these were not named. Any precise naming ran the risk of obscuring the empirically derived characteristics of TOR's with subjectively derived explanations and surplus meaning associated with the names chosen. TOR's were thus described by noting characteristics common to those tasks most strongly influenced by each TOR. The usual language of social work was used in these descriptions.

TOR I was a requirement for an activity directed at the student himself, by the student, with aspects of self-criticism and self-control. It appeared to involve the activity of introspection, self-assessment, and self-discipline in connection with both the student's feeling and his overt activity. In dealing with written material other than recording, self-criticism and self-control influenced performance negatively or toward unsatisfactory performance. These tasks required an activity the opposite of self-criticism and self-control, but still an activity directed at the student by himself

rather than toward others. If verified by further study, this TOR may explain why a profession that practices self-control finds it difficult to produce the more and better literature that it demands.

TOR II was a requirement for an inductive-deductive, analytic-synthetic kind of activity. The tasks it influenced indicated it involved taking in various stimuli, comparing these with various other stimuli and with knowledge within the person, and after some cognitive process, arriving at a basis for activity in terms of some whole into which these various stimuli and knowledge were integrated; or, the taking of some generalization and finding observations or stimuli that fit in with the generalization. The integrative-inductive phase of TOR II most strongly influenced performance in tasks where the student reacted to his supervisor, where he integrated theory and practice, and where he acted on or controlled his own actions. The analytic-deductive phase influenced tasks classified under the student's reactions to casework theory. A combination of inductive and deductive activity influenced the establishment, maintaining, and use of the casework relationship, though TOR II was not the only TOR influencing the casework relationship.

TOR III was a requirement for a communicating kind of activity, involving the communication of certain ideas either orally or in writing, explicitly or implicitly. It had aspects of clarity, conciseness, and promptness. Tasks most heavily influenced by this activity were recording and those dealing with other written material. However, getting along with others, acting on the client (treatment), and dealing with community resources were also influenced by this TOR to a significant extent.¹⁰ The influence of TOR III on the use of community resources may be related to the fact that many contacts with community resources were carried out by letter. Further

⁸ Correlations between each classification and every other classification were computed on the basis of ratings above. The centroid method of factor analysis was used on the correlation matrix so obtained to provide the smallest number of factors, or influences responsible for these correlations.

⁹ An analysis of variance made of the ratings for each student in each classification suggested there were differences in tasks themselves, and that these differences had not been lost in classifying tasks. The estimate of variance made from the means of classifications was significantly greater (at the one percent level) than the estimate of variance derived from student-classification interactions, or the estimate of variance derived from within students.

¹⁰ The term "significant" as used above and in the following material means significantly different from chance at the 5 percent level of confidence.

study is needed to clarify the relation of ability to communicate to use of community resources.

TOR IV was a requirement for an accepting, conforming, adapting kind of activity. It heavily influenced tasks involving diagnosis and had some significant influence on treatment. It was important in determining the student's reaction to the agency, and to a minor, but yet significant degree, effective in how the student used both supervision and the worker-client relationship.

TOR V was a requirement for a help-seeking kind of activity with aspects of recognizing when help was needed as well as knowing which sources were appropriate for providing different kinds of help. It most strongly influenced the student's use of supervision and almost as strongly influenced the organization of the student's work. To a lesser but still significant extent, it influenced the student's reaction to social work values, the worker-client relationship, and the student's diagnostic activity.

TOR VI was a requirement for obtaining co-operation and acting co-operatively with other students, staff workers, and persons in other professions as well as obtaining the liking and respect of other students, staff workers, and others. It most heavily influenced how the students got along with coworkers and persons in other professions. It had some influence on how the student reacted to or identified with social work values, and also a significant influence on how the student organized his work.

DISCUSSION

This study attempted to learn if performance of social casework tasks was influenced by something in the tasks. In this way it was different from other studies of influences on performance that have sought influences on performance in variables within persons.

"Somethings" in tasks that influenced

performance were indicated by variations in performance that remained even when influences within persons (students) were minimized. These somethings were conceptualized as Task-Originated Requirements for certain activities by the student and were called TOR's. Six TOR's were found to account for almost all the residual variations in performance mentioned above. While it is possible that these Task-Originated Requirements represent the common way supervisors conceptualize tasks, there is some evidence they are something else, that is, underlying influences on performance emerging from the casework tasks themselves. The Task-Originated Requirements as found in this study had no similarity to any outline or conceptual framework known to be used by the supervisors studied. Relationships among TOR's found tend in some cases to contradict what is currently believed about casework tasks. For example, completion of some tasks seemed to require self-control, while in other tasks self-control influenced performance negatively or toward unsatisfactory performance.

The immediate applications of the concept of TOR's to education and practice have been mentioned. In addition, as TOR's found in this study are confirmed and extended from similar and other sources of data, they offer a fruitful way of looking at some of the broader questions with which the profession is concerned. If we knew whether certain TOR's are specific to various casework specialties, this would help to increase knowledge of the specific and generic content of practice. Information on whether different or identical TOR's are required by tasks carried out during various semesters of student training has applications for education. Knowledge of which TOR's are found throughout the field of social work should be helpful in formulating a uniform theory for the field. And finally, understanding how TOR's in social work relate to TOR's in allied fields can help to fix the boundaries of social work itself.

POINTS AND VIEWPOINTS

Nomenclature: An Aspect of Communication

MISS HAMILTON'S PERCEPTIVE editorial (*Social Work*, April 1958) characterizes Miss Bartlett's and Dr. Boehm's papers in the same issue as "timely and provocative." Surely no more urgent task awaits the profession than that of building more adequate formulations of the ideas that constitute the body of social work knowledge. It is significant that Miss Hamilton ends her comment with a reference to the need for standardization of basic usage.

This need is evident, for there are inadequacies of social work terminology, including a varied and often inconsistent usage of key terms, that stand as impediments to more useful formulations of professional knowledge. Clearly, more accurate and consistent usage of professional nomenclature can facilitate the development and organization for communication—and especially for teaching and learning—of the growing body of knowledge we have in social work.

Social workers sometimes have decried the use of technical language on the ground that it interferes with an understanding by lay people of what social work is and of what it tries to do. Actually this both understates and oversimplifies the issue for, as Miss Hamilton implies, there are two problems here demanding the attention of the profession, not one.

Communication with lay people—with all the several publics concerned with social welfare—does urgently need improvement. The explanation of what it is that social workers do—and why—needs to be done more effectively. Social workers do need skill in language—basic and expository English. Social work communication needs more skillful use of the apt illustration, the epigram, the pungent phrase, and the tell-

ing anecdote than is evident in much of our writing.

Nonetheless, even optimum public interpretation will leave unsolved the more important problem of formulating social work knowledge so that it can be communicated to other social workers. Only progress in the latter effort can give us, eventually, a body of practice well understood by members of the profession. That achieved, the task of explaining it to others will be more nearly within our abilities.

Social work requires a nomenclature adequate to communicate intricate acts and subtle ideas of great complexity. The what and the why of helping individuals and groups and communities involve more than simple concrete acts and ideas. These intricacies have to be expressed, clarified, and communicated by our professional terminology. A number of writers, perhaps Boehm¹ most comprehensively, have given this problem serious attention. Despite this, one has only to begin reading in social work literature to recognize that such terms as *concept* and *principle*, *generalization* and *theory*, *method* and *process* sometimes are used synonymously and sometimes differentially—not infrequently by the same writer in the same work. The term, *concept*, for example, is especially abused by being applied indiscriminately to every order of idea from concrete clinical observations to abstractions of the highest type. Such undisciplined usage stands in the way of the systematic ordering of social work ideas. A disciplined use of language is basic to the creation of the typologies necessary for systematic formulations of our social work knowledge.

There is no gainsaying the limitations of

¹ Werner W. Boehm, "The Terminology of Social Casework: An Attempt at Theoretical Clarification," *Social Service Review*, Vol. 28, No. 4 (December 1954), pp. 381-391.

some social work nomenclature and the widespread dissatisfaction with some of it. Some people carry this dissatisfaction to the point of deprecating the very name of the profession, and it is no rarity for agencies to depreciate it by bootlegging its practice as "counseling" or some other euphemism. The problem, furthermore, is far from new. Alexander Johnson advocated *asthenontology* as an appropriate designation for our practice.² To him none of the terms then current—*charities*, *philanthropy*, *social work*—was as satisfactory.

That Johnson's coinage gained no acceptance as legal tender in the market of social work ideas does not prove that made-words are spurious, but it argues that mid-century contrivers will encounter difficulty in displacing terminology of wide current usage.

Although the profession might coin new names and develop unique definitions for its terms, there are cogent reasons why our professional vocabulary should approximate closely ordinary usage. First, because of its similarity to vernacular English such usage is likely to facilitate communication between social workers and the larger numbers of workers in the social welfare field who have not had the discipline of professional education. Second, it should increase the ease of communication among social workers, social scientists, and the practitioners of other professions with whom interdisciplinary relationships are desirable. For

example, while communication among social workers might not be impeded by applying the term *concept* to that order of abstract ideas which social scientists commonly designate by the term *principle*—assuming that we could maintain a consistent usage among ourselves—communication with social scientists almost certainly will be easier if we can designate as *concepts* abstractions of the order that social scientists usually characterize by that term.

It is suggested that the development of more uniform social work usage will be facilitated by the application of two criteria:

1. *Definitions should be based upon common scientific usage as set forth in standard dictionaries.*

2. *Other considerations being equal, meanings that have acquired a standard usage in the social sciences should be accepted by social work.*

To illustrate how these suggested criteria might be applied in developing a useful glossary of social work terms, but in no sense as finished formulations, several definitions are advanced. The leading definition of each term has been extracted from *Webster's New International Dictionary*, 2d ed.; the supplementary definitions, expositions, and illustrations from social work and social science sources have been developed by the writer and selected to indicate consistent applications and usage.

VERL S. LEWIS

University of Connecticut
School of Social Work

² *Adventures in Social Welfare* (Fort Wayne, Indiana: The Author, 1923), p. 130.

GLOSSARY

Webster's definition

concept

An idea, as distinguished from a percept; especially, an idea representing the meaning of a universal term and comprehending the essential attributes of a class or logical species; an idea that includes all that is characteristically associated with or suggested by a term.

In social work

An abstraction representing a complex idea, e.g., *relationship*, *psychosocial diagnosis*; from psychoanalysis: *ego*, *ambivalence*, *Œdipal conflict*; from sociology: *anomie*, *functional community*, *nuclear family*, *social role*.

Such concepts as *self-determination* and *confidentiality* usually imply a percept, in which case it is proper to refer to them as principles, e.g., "the principle of self-determination." Strictly speaking, however, the statement of such a principle requires making explicit qualifications that necessitate the form of a proposition. (Author)

Points and Viewpoints

GLOSSARY (continued)

Webster's definition

In social work

generalization

Act or process of generalizing. A general inference. *Generalize:* To make general; to reduce to general laws; to give a general form to. To derive or induce (a general conception or a general principle) from particulars.

An idea evolved by induction from particular observations. An abstraction denoting the common elements in two or more observed phenomena. (Author) "The generalizations from the specific data of practice will give us the relations of correlation and perhaps eventually of causation. They will tell us, for example, when we find 'this' situation, there is, in varying degrees of probability, the likelihood of 'this' result." (Coyle)

method

An orderly procedure. . . ; regular way or manner of doing anything; hence, a set form or procedure adopted in investigation or instruction. Orderly arrangement, elucidation, development or classification; systematic arrangement peculiar to a . . . given matter; plan or design; . . . orderliness and regularity or habitual practice of them in action. Method is commonly a special or definite system of procedure.

The major systems of helping practice in social work, *i.e.*, casework, group work, community organization. (Author) "Social group work is one method in the profession of social work. The other methods are social casework and community organization work." (Trecker) "Casework as a method refers to specific activities directed toward a treatment goal." (Boehm) "The social work method is the responsible, conscious, disciplined use of self in a relationship with an individual or group." (Bartlett)¹

¹ It will be noted that Bartlett implies a generic quality not indicated—but perhaps not excluded—by Trecker and Boehm.

principle

A comprehensive law or doctrine from which others are derived or on which others are founded; a general truth; an elementary proposition. "A *principle* ascertained by experience is more than a mere summing up of what has been specifically observed in the individual cases which have been examined; it is a generalization grounded on those cases." J. S. Mill. A settled rule of action; a governing law of conduct; an opinion, attitude, or belief which exercises a directing influence on life and behavior; a rule . . . of conduct consistently directing one's actions.

An abstraction from observed phenomena which serves as a precept, a rule for action or a guide to conduct. Such concepts as *self-determination* may properly be denoted principles if used in such a way that an implicit precept is made clear. Usually the explicit qualifications required by such usage necessitate the statement of a principle in the form of a proposition. (Author) "The principle . . . will answer the question of what, in a given situation, we as social workers *should* do." (Coyle) "A principle is a rule for action or a guide for behavior." (Boehm)

Examples: "The Association should develop a pace for its work relative to existing conditions in the community." (Ross) "Help is most effective if the recipient participates actively and responsibly in the helping process." (Hamilton) "The first business of caseworker and client is to learn the facts of what the problem is as it exists, seems and feels today." (Perlman)

process

Act of proceeding; continued forward movement; procedure, progress, advance; . . . something that occurs in a series of actions or events. Any phenomenon which shows a continuous change in time . . . ; as, the *processes* of nature; the *process* of growth. A series of actions, motions, or operations definitely conducing to an end, . . . progressive act or transaction; . . . a method of operation or treatment . . . *process* denotes a progressive action or a series of acts or steps.

The planned interaction of social worker and client, group, or community for the purpose of change. (Author) In casework: "The specific interaction between client and worker, providing it takes place within a time span and involves a beginning and an ending and envisages the possibility of change." (Boehm) "The social group work process [is] a purposive and disciplined way of affecting the group process." (Kaiser) "The result sought in this process is primarily greater capacity on the part of the community to function cooperatively in respect to common problems." (Ross)

Mental Illness and Health—Research and Service

WITH THE COMING and passing of World War II, public awareness and professional concern about the problems of mental health have multiplied manifold. The first demand was for more of what we already had, that is, more hospitals, more clinics, more publicizing the incidence of illness, more use of dynamic psychology in school and home, and more trained professional personnel in the healing arts. That these answers were too easy and hopes too high is now clear. Even a glance at the titles of books in the field suggests that our attitude has become less sanguine and more realistic; that we are questioning old answers and asking new hard questions which only research can answer; that the solution of the problem requires the combined efforts of government and voluntary organizations of professional associations and operating agencies, and of a teaming up of our best resources in education, research, community organization and the several helping and healing professions. Glib overconfidence has yielded way to earnest inquiry and searching for facts that will throw light on causes of illness and sources of health, and that will meet the demands that we put to the test of social adjustment the outcomes of our therapeutic efforts.

Service and research especially seem to have joined hands as in a marriage for life, with the honeymoon and dreamhouse phase already ended. Both are facing realities and working together with mutual respect and considerable hopefulness. Staff devoted to service to patients are welcoming the help of biological and social scientists in learning more about the causes of illness, an understanding of which is necessary to prevent illness, to build health, or effec-

tively to treat the ill. Those engaged in research, on the other hand, are moving beyond the "pure research" approach to action and operational research, and are discovering that significant findings are to be achieved by teaming up with service staff in the biochemical studies of the human organism and in the critical study of the social structure of therapeutic institutions and agencies, and of the broader social scene from which patients come and to which they return.

With this combined search for etiological facts and therapeutic effectiveness has come a readiness to team up in new combinations of approach and professional disciplines, of greater willingness to work together on the part of various groups whose respective roles are study and research, diagnosis and treatment, community organization and administration, and education and training. In brief, it is a period characterized by organization in depth and of collaboration in both horizontal and vertical dimensions.

RESEARCH CONFERENCES

The Patient and the Mental Hospital, edited by Milton Greenblatt, Daniel J. Levinson, and Richard H. Williams (The Free Press, \$6) reports a research conference on socio-environmental aspects of patient care in mental hospitals. It combines 35 original presentations with discussion by the conference. Included are studies of mental hospital organization and its implications for treatment, study of therapeutic personnel, of the ward, and of the patient and his extra hospital world. It is clear from this study that hospital administration is of

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two types: in the one, the aim is to run an efficient plant, and personnel are expected to run an efficient, orderly, and smoothly functioning organization in which the patients, who are the materials and the products, are sometimes secondary to the machine. In the other type of hospital, the patient is the primary object of interest and the philosophy of the administration is to make the entire hospital plant and personnel "a therapeutic milieu," in which every employee becomes involved in employee-patient relationships and the focus is on whatever will help the patient to get well. This involves flexibility and co-operation among disciplines and constant training in new techniques.

The writers graphically describe the trials and tribulations of research in a hospital setting where administrators want early practical results that may interfere with the scientists' continuing purer forms of research. On the other hand, the research often leads to findings that point to the need for changes that may inconvenience or embarrass the administration. Several contributors discuss the function of social workers, psychologists, and others in their individual and team roles and the employment of group therapy with patients and family in integrating patients into the community. The book gives a valuable and comprehensive overview of the treatment of patients in mental hospitals, evaluating both past and current trends, and pointing to new developments as research points the way.

The institute reported in *Four Basic Aspects of Preventive Psychiatry*, edited by Ralph H. Ojemann (Iowa City and State University of Iowa, \$2) was devoted to four aspects of preventive psychiatry, namely (1) a clarification of the concepts of prevention and creative development, (2) an examination of recent data on factors associated with the prevention of mental illness, (3) a critical analysis of recent research on the effects of education on human development, and (4) suggestions as to next steps in research.

The conference recognized that although writings and thoughts on the subject of mental health and mental illness have been directed to individuals with a search for a specific etiologic or pathogenic agent, inquiries that are going to yield worthwhile findings about the adaptation of the individual to his environment must be directed to both poles of this process. Hence, the conference directed its attention largely to the question, *What is it in the socio-cultural environment to which people must adjust that is evocative of difficulties in adjustment, and what is it in the individual which has gone wrong in the developmental process in relation to this mutual process of adjustment?*

The book will be of interest and value alike to persons engaged in research, case-work, or clinical services. The reviewers are impressed both with the difficulties in carrying on research that is slanted toward prevention and with the absolute necessity for further research in the field. For example, in Dr. Brimm's summary of research on the effects of education in human development, it is clear that at present there are many competing theories about what, if any, are the specific characteristics of parents, teachers, and children that promote mental health or cause mental illness in children. The most that can be claimed for research studies of this is to add slightly to the plausibility of desirable effects from mental health education, yet two of the more thorough studies suggest that it may not be possible to promote mental health by educational means.

Psychiatric Inpatient Treatment of Children (American Psychiatric Association) is an account of the conference on this subject held in Washington, October, 1956, supported by the National Institute of Mental Health, and held under the joint auspices of the American Psychiatric Association and the American Academy of Child Psychiatry. The conference dealt exclusively with the care and treatment of emotionally disturbed children in inpatient

medical settings. The book is a summary of the findings of the deliberations of several days on the part of four working groups. Among the factors considered were community relationships, plant, location, cost, personnel, treatment processes, research and epidemiology.

The development of psychiatric care for children from the early 1920's to its present status is traced. The first facilities were in public psychiatric hospitals and were designed to care for children with organic illness, such as encephalitis. Subsequent developments opened the field of interest to the residential treatment of emotionally ill children, such as delinquents and children with developmental distortions. More recent developments have been an increasing use of individual psychotherapy, milieu therapy, and a "total treatment program in many treatment centers."

The book is a well-organized presentation of what a children's hospital for disturbed children is and does. The principles and suggestions set forth will be of considerable value to any community considering the addition of such a facility to its mental health resources. It clarifies the functions of the hospital in the community, and then deals in specific terms with the program, equipment, organization, staffing and other factors that should be taken into consideration. It also indicates the kind of survey a community needs to make before embarking on the establishment of a children's psychiatric hospital. This will be of interest not only to social workers engaged in treatment programs, but to those concerned with community organization and planning as well.

The participants in the conference reported in the *Proceedings of the Conference on Research in the Children's Field* (National Association of Social Workers, \$1.50—reprinted from *Social Service Review*) represented all areas of social work, and were outstanding practitioners, researchers, and administrators. The conference papers are related to foster home care

and adoption, institutional treatment of the disturbed child, psychiatric clinic services for children, group work with children and youth, and the facilitation of research. All the major problems were approached by a discussion of the unanswered questions and a consideration of the problems and possibilities of research in each area. The number of unanswered questions and the seriousness of problems in research that could hopefully provide answers to some of the questions are impressive both as to their number and the degree of difficulty involved. It will be apparent to readers, as it has been to the reviewers, that many of the answers that seem so settled many years ago are again opened up for deeper explanation. This is clearly a healthy sign that the field is not just becoming larger, but that those engaged in it are inquiring into the underlying causes of behavior at its deeper levels.

Productive research appears possible only when there are centers organized specifically for research, when social work agencies furnish the clinical data and carry out projects to supply the basic material. When schools of social work as well as agencies train students to become research-minded because they need to and want to, such social workers themselves will create the necessary practical arrangements. A selected bibliography of 223 references is included. This comprises an impressive array of research projects and critical looks at social work practice.

NEW COMMUNITY SERVICES

Communities and the nation as a whole have become much interested in services to the mentally retarded, an interest which is being expressed in demand for new legislation to make possible both research and expanding services. The study reported in *The Adjustment of Severely Retarded Adults in the Community* by Gerhart Saenger (New York State Interdepartmental Health Resources Board) is a long-term follow-up of the adjustment of 2,640 se-

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verely retarded adults in the New York City community who had attended low I.Q. classes (I.Q. under 50, mostly 40-50) during the period 1928-56. The study was carried on by the research center of the Graduate School of Public Administration and Social Service, New York University, for the Interdepartmental Health Council of the State of New York by a team of psychologists, social workers, and statisticians. Homes and communities of patients were studied; detailed evaluation of the psychological care of the patients was made through interviews with them and their relatives, all of which yielded rough measurements of these patients' community adjustments.

Findings are that 74 percent of these patients have remained in the community; 26 percent of the original group have been institutionalized, usually during the school years; 27 percent were employed in various types of jobs that made it possible for them to be partially or solely self-supporting. As might be expected, the patients who have made the best adjustment within their individual limitations have been those who received the benefit of warm acceptance, independent home training, and assistance in working out their community relationships. The study further indicates that much can be done to help families, through counseling and community resources, to make institutional care unnecessary in many cases. One further effect of the study is to dispel some of the pessimism that has come over institutions for the retarded and encourage a dynamic therapeutic program to help each patient achieve his highest potential of functioning. Social workers will find leads for increasing their effectiveness in the use of community resources to remove obstacles to community adjustment.

Another trend in the mental health field during the past decade has placed increasing responsibility on local communities for the planning and development of a broader spectrum of community services to supplement the service of the psychiatric hospital



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to the severely ill. This trend has found expression in legislation in several states, the first of which was New York, which provides for the establishment of public mental health boards under local government. *Mental Health Resources in New York City* (NYC Community Mental Health Board) describes the efforts of the Mental Health Board in the country's largest city to assemble significant facts regarding the city and its population. It takes a look at previous surveys of needs and facilities, and describes various special studies which the mental health board has carried through as a preparation for planning expanded and improved services, and adds a summary of observations of staff based on field reports. It may serve as a helpful model to other communities wishing to assess their needs and facilities and plan realistic programs.

LUTHER E. WOODWARD

WALTER JOHANSON

New York State Department of
Mental Hygiene

PRESCRIPTION FOR SURVIVAL. By Brock Chisholm. New York: Columbia University Press, 1957. 92 pp. \$2.50.

This is not exactly a book: it is, rather a recording of four "words fitly spoken." They constitute an authoritative, concentrated formula to save the human race from death by war. Says Dr. Chisholm, "My subject may be unlimited, but my time and space are not." Therefore he must generalize. The result, to put it into a capsule, is the considered judgment that in order to live, man must change.

As with the prescription, so also with the reaction of the patient to the medicine. Change requires time and space, and there is no time, and little space on earth. Already, "Man's ability to kill has reached a universal level." Nevertheless a physician who is also a statesman, and courageous, can hold out some hope.

Rx: Let each man of the present generation begin with himself and free himself from bondage to the past and to his locality. Let him then give his children, the coming generation, the same freedom with love. In international relations, instruction is useless. Organization alone will not save us, but organization as in the United Nations is an instrument to be used with realism and imagination by peoples whose attitudes toward themselves and others are changing. "Imagination is an extremely valuable instrument—if it is free, if it is allowed to tell the truth, if it doesn't deal in fantasy and myths and magic, but deals in realities."

To an old medical social worker the value of a prescription resides not alone in its authority but also in its compounding by the pharmacist and its swallowing by the patient. Dr. Chisholm's patient is mankind. He speaks first and foremost to the natives of North America. The lectures have been published in Great Britain, Canada, India, and Pakistan. They were addressed to a university in social action.

Social work, it would seem, as one of the

existing agencies for implementing and distributing ideas, has a part to play in making such a prescription as this useful for survival. Within the content of social work education this book would promote discussion. Some controversial points are made in it, notably in regard to religions. Its effect on survival depends upon widespread acceptance and action.

ANTOINETTE CANNON

New York, N. Y.

THE VOLUNTEERS. By David L. Sills. Glencoe, Ill.: The Free Press, 1957. 320 pp. \$6.00.

The Volunteers is a fascinating study of the National Foundation for Infantile Paralysis, by the acting director of Columbia University's Bureau of Applied Social Research.

This book is scholarly, objective, and very interesting. It has a dual focus. It examines a representative number of volunteers—their reason for joining, their image of the Foundation, the relative satisfactions from different aspects of the program. At the same time it analyzes the problem of the Foundation as an organization—which must maintain membership interest, and yet keep its goals intact.

Considerable statistical data are presented so that the reader may judge for himself the validity of the conclusions. These seem to be objective, well supported, and reasonable. Of even more interest to this reader was the way in which Dr. Sills integrated throughout the text the findings of other social scientists who have studied the problems of organizations and bureaucracy.

Because the voluntary organization is an important aspect of American democracy, Dr. Sills is hopeful that much can be learned from this case study of a successful organization. Certainly it would be hard to duplicate the factors, both planned and accidental, which were so fortuitous for the Foundation—a revered founder, a non-controversial goal, overwhelming public

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response, built-in turnover, direct tasks to be done locally with a minimum of rules, centralized authority. In this book there is much that each of us who works with volunteers, or worries about organizational structure, can learn from the analysis of each aspect.

Like a good cliff hanger, we are left with a question: "Now polio is virtually conquered, can this inspired body of volunteers move on to a new goal?" While the Foundation works on *that* chapter, read the book!

MARGARET BERRY

*National Federation of Settlements
and Neighborhood Centers
New York, N. Y.*

GROUP LEADERSHIP IN STAFF TRAINING. By Eileen A. Blackey. Washington, D. C.: U. S. Department of Health, Education, and Welfare, 1957. 176 pp. 55 cents.

In preparing this study for her doctorate the author gathered together the experiences of public welfare staff members engaged in group training activities in thirty states and found that progress in the quality of staff training through groups has not kept pace with that made in teaching through individual supervision. Three areas of knowledge are essential for leaders of training groups: content of professional social work, educational principles and methods, and group processes and functioning.

This knowledge is available in the social sciences, education, social group work, and allied fields. Group training is a natural part of the educational process in any staff development program. It is necessary, therefore, to understand the processes of group formation and group deliberation and to acquire the knowledge and skills essential for using them effectively. This means provision for the training of those who train others, beginning with knowledge now available and including further research.

It is likely to be of most interest to social

workers in administrative, supervisory, and staff development positions. It will also be of value to persons interested in adult education and to personnel responsible for group training in the new profession of public administration.

This publication fills a lack in materials for staff development purposes which public welfare staffs have felt in recent years. It points up some sources of knowledge in allied fields applicable to in-service training through groups. It provides a framework and impetus for a fresh approach in conducting such training. The bibliography is valuable.

The value of the content warrants a wider use than this book will probably have in its present study form. It is soundly and imaginatively developed and clearly written, but requires concentration and study. However, a beginning could be made toward immediate use of some of its stimulating content by excerpting and reorganizing (from Chapters 3, 6, 7, and 8) materials dealing with the educational process in the agency setting, the formation of groups and what it takes to be a successful group leader or participant, and thus promote a wider use.

LORA B. PINE

*Allegheny County Board of Assistance
Pittsburgh, Pennsylvania*

BRIEFLY . . .

THE PLANNING OF REHABILITATION CENTERS. Washington, D. C.: U. S. Department of Health, Education, and Welfare, 1958. 322 pp. \$1.25.

The proceedings of a 1957 institute, this volume gathers thirty papers by well-known writers, covering important topics such as: how the need for a center is evaluated; what is required to finance, staff, and create the physical plant; and center relationships to various levels of government. The material dealing with the work of the various disciplines active in centers is of particular interest.

ALFRED H. KATZ

SOCIAL PERSPECTIVES ON BEHAVIOR. Edited by Herman D. Stein and Richard A. Cloward. Glencoe, Ill.: The Free Press, 1958. 666 pp. \$7.50.

This is a Reader in social science for "social work and related professions," edited by two members of the faculty of the New York School of Social Work. Gordon Hamilton contributes a Foreword to the volume in which she asks and discusses the question, "Why is this volume so timely—so much needed today?" The editors in their Preface state that "This book of readings is intended to enable both the student and experienced social worker—as well as the teacher, psychologist and psychiatrist—to familiarize himself with concepts and findings in the social sciences which are relevant to professional practice."

If one did not know that Readers in the social sciences are fashionable, he would learn this from the titles of the eighteen "Free Press Readers" listed on the jacket of this particular volume. These are Readers, not *source* books such as Edith Abbott and Sophonisba P. Breckinridge prepared for the profession of social work. The source books compiled by Abbott and Breckinridge made available collections of published documents not readily at hand as well as often unpublished case material that threw light upon some of the historical, legal, and social aspects of a given subject, such as immigration. In contrast to source books such as theirs, this collection of fifty-three pieces of material is related to no single topic but rather to a complex the editors have called "Social Perspectives on Behavior." Also in contrast to the source books this collection does not make available to the student items that are difficult for him to obtain for himself, since twenty-six or approximately half the volume's contents consists of chapters or abridged chapters from books which have recently been published. Not one of these chapter items antedates 1926 and twelve have been taken from books published during 1950–1957.

It can be assumed that these books are available in any university or sizable municipal library. Since a Reader is not a source book, it can be maintained that the inclusion of chapters from books recently published and readily available is fitting and proper. I suppose it can also be maintained that the student or practitioner has neither the time nor the inclination to go to the library and that he prefers to pay others to select his social science reading for him. If he went unaccompanied by the editors in search of knowledge from the social sciences he might discover David Riesman, a social scientist whose writings for some reason the editors have chosen to ignore, and become intrigued with his reconsideration of the principle of individualism as a moral influence and the freedom of the individual as the first criterion of social good. This leads Riesman to define the right relation of the individual to society as that of "conditional co-operation" in specific short-term enterprises, rather than a total commitment—an idea that might well be considered in any volume on "Social Perspectives on Behavior."

In stating this I am also saying that I, like any other reader of this Reader, am inclined to quarrel with the editors over their selection of items. Too many of the items are, or seem to me to be, interesting but too remote from "knowledge that hath a tendency to use." And the editor's introductions are not always too helpful in this respect. For example, if the section on "Values" were rechristened "Value Conflicts" the items selected would have had to be more sharply focused on today's chapter in the "American dilemma." Quarrels over the inclusion and exclusion of material selected for any Reader can continue endlessly. Such disagreements are, or can be, profitable and it is to the credit of the editors of this Reader that their selections will tend to quicken our interest not simply in the social sciences but in material from these sciences which is or can be of use to us in our teaching and practice. The

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preparation of any Reader on such a large general subject presents more problems for its editors than would a Reader on a more circumscribed topic prepared for an audience limited to social workers.

Whether any Reader on any subject is the only or preferable way to call attention to "illuminating and provocative ideas" from the social sciences "that can be incorporated into the thinking and practice of the social worker and other professionals" is an open question. I am inclined to think that a volume, or one similarly planned around a different problem or problems, such as *Physical Handicap and Illness: A Survey of the Social Psychology of Physique and Disability* prepared by Roger G. Barker, Beatrice A. Wright, and Mollie R. Gonick (Social Science Research Council, 1946) is preferable to a Reader. The editors' motivation in preparing this volume was to bring together what was known about adjustment to physical handicap and illness and to point out problems for investigation. The critique by Dr. Barker and his associates based on "a careful review of several hundred studies" does not furnish a complete body of knowledge concerning adjustment to physical handicap and illness. The findings are suggestive rather than conclusive but these suggestive findings, this limited knowledge is what we have for use today in such important practical matters as doctor-patient relations, vocational rehabilitation programs, and so on. The material in any one of the chapters on somatopsychological significance of crippling; psychology of the tubercular; somatopsychological significance of impaired hearing; social psychology of acute illness; employment of the disabled is knowledge social workers can use, and be aware at the same time that research in these matters "has had serious limitations either in method or in the small number of cases studied."

When, as social workers, we seek material from any other discipline that may be of use to us in our practice, we have to find

appropriate ideas useful to us in understanding the specific problem or phenomenon we are observing and/or modify for use the ideas we have found. Although as social workers we are seldom articulate about the transforming powers that we possess and use, it is evident that by passing psychological or any social science concepts through the medium of our own sensibility, through the furnishings of our own minds and the gleanings of our direct experience with clients or with groups, we often turn what we have called social science concepts into something different—into a social science for use in our own practice. And so, as a second preferable substitute for another Reader, I am hoping that Herman Stein and Richard Cloward will write their own book on "Social Perspectives on Behavior." With the knowledge both have of social work and of social science as well as the new ideas they are obtaining through their "re-development of course material on the relationship of social science to social work practice," they are becoming prepared to make such a contribution to the profession.

FLORENCE SYTZ

Tulane University
School of Social Work
New Orleans, Louisiana

BRIEFLY . . .

REVIEW OF SOCIOLOGY. Edited by Joseph B. Gittler. New York: John Wiley & Sons, Inc., 1957. 588 pp. \$10.50.

A group of outstanding sociologists has summarized progress in sociology during the last decade. An excellent reference book for those who want to catch up on current thinking and research. Especially pertinent chapters on social institutions and voluntary associations, marriage and the family, and the sociology of delinquency and crime.

LEONARD KOGAN

COMMUNITY CHEST—A CASE STUDY IN PHILANTHROPY. By John R. Seeley, B. H. Junker, R. W. Jones, Jr., and Associates. Toronto: University of Toronto Press, 1957. 594 pp. \$7.50.

Any reader who approaches this book expecting the conventional will be disappointed. Both in purpose and in pattern it represents deliberate departure. If specialists in joint fund-raising hope primarily to find tips and techniques in campaigning they will search in vain. If enthusiasts for United Funds and United Appeals expect uncritical acceptance of basic assumptions and operating principles they will encounter rough going. If those who have undertaken studies in the financing of voluntary health and welfare programs on a community-wide basis imagine that here is just another case study to add to their collection they will be mistaken. Anyone who knows the senior author and director of the study here reported, John R. Seeley, can be certain of a three-dimensional research design—historical, socio-cultural, and philosophical.

This book is much more than a case study of a particular Community Chest (Indianapolis). It is, as the subtitle suggests, a study in philanthropy as such. Dr. Donald Young, director-general of the Russell Sage Foundation, which has devoted much attention to research in this relatively neglected field, contributes a discerning foreword in which he identifies handicaps limiting the effectiveness of philanthropy and evidence of growing concern about the facts and future of philanthropy in our society. Seeley and his research team have greatly illuminated an extremely complex area of modern life both in terms of the motivations and the machinery involved in *mass, operational, periodic, secular* fund-raising.

What might have resulted in a quite arbitrary delimitation of the assignment to a segment of giving, in one section of America, focused on one city and indeed upon one particular institution, at one par-

ticular time is happily avoided. The authors provide essential context (local, state, and national), comparison with forty-one most nearly relevant cities, and exhaustive examination of ideological as well as operational considerations.

Here is a book, at long last, focused on one of the most crucial areas of modern life, voluntary support of voluntary social services, a vast mobilization on the frontiers of human need in a rapidly expanding, industrial society, hopefully paralleling and complementing huge tax expenditures for basic public services. Unlike many, if not most, studies concerned with financing the social services, this is an inquiry guided by penetrating theoretical formulations, pursued with unusual ingenuity and sophistication, and characterized by impressive social sensitivity and scientific objectivity.

Because this study is concerned primarily with voluntary support of voluntary social services, some public administrators may think that it has little or no relevance for them. Such a conclusion is both unwarranted and unwise. Voluntary philanthropy, particularly in relation to large corporations, where tax allowances are involved, must always be examined in relation to fiscal policies and also in relation to the roles and responsibilities of public and private organizations. The situation is highly dynamic and changes in attitude, policy, and practice occur continuously.

This book will disturb and distress many people. It will do so because it invades a realm of collective privacy and violates something akin to a place of collective sanctuary. It provides, in the last analysis, a profound, penetrating, and provocative redefinition of the situation. In the opinion of this reviewer a passage contained on pages 401 and 402 of the book is as constructive and challenging a formulation of the problem and prospects of philanthropy as he has come upon in many years.

CHARLES E. HENDRY

University of Toronto
School of Social Work

Social Work

Book Reviews

CASE HISTORIES IN COMMUNITY ORGANIZATION. By Murray G. Ross. New York: Harper & Brothers, 1958. 259 pp. \$3.50.

This book carries forward ideas the author presented in *Community Organization: Theory and Principles* (Harper and Brothers, 1955). Essentially it consists of four parts: Part I is a frame of reference; Parts II and III each include five vignettes describing factors affecting interpersonal, intragroup, and intergroup relations; Part IV is made up of eleven case histories of community projects, including three that have been published elsewhere.

Five approaches to working with communities are presented, with emphasis on the proposition that ends are predetermined in means. Dr. Ross states, "If community organization is to be a part of a more general practice of social work, this fact sets further limits on what it may properly include." He considers the *reform*, *planning*, and *process* orientations as most usually applied in practice. That these three might be merged into a "single approach with *planning* and *action* representing stages . . . of the *process* orientation" seems worth further development.

This reviewer considered Part I, which included creative adaptation of concepts and schema from the behavioral sciences, a stimulating contribution. Social workers may need to note that the documents which make up most of the book are not called case records. This may explain the lack of sharp delineation of the worker's involvement, and this reviewer's feeling that they tend to reflect the wider field despite the author's stated identification with community organization as a social work process.

Humor, perhaps intentionally, is included in one report: "The head of the local School of Social Work became vice-president and the treasury was taken by the police sergeant." Controversy is also suggested in a brief discussion of social action and social change in which it is questioned "whether the means of achiev-

ing these ought to be through the use of a social work process."

This book should be read by practitioners in the broad field of community work; for social workers, beyond the first 27 pages, it would seem optional.

BERNARD ROSS

Michigan State University
School of Social Work
East Lansing

REGENT PARK. A Study in Slum Clearance. By Albert Rose. Toronto: University of Toronto Press, 1958. 242 pp. \$5.50.

COMMUNITY ORGANIZATION FOR CITIZEN PARTICIPATION IN URBAN RENEWAL. By William C. Loring, Jr., Frank L. Sweetser, and Charles F. Ernst. Cambridge, Mass.: The Cambridge Press, Inc., 1957. 238 pp.

The subject matter of these two books is the creation and sustaining of a better life for citizens in the urban environment, as reflected in slum clearance and low rental housing in Toronto, Canada, and urban renewal in Boston, Massachusetts. Social workers can gain much information, knowledge, and insight from these reports which, if assimilated, will make them far more realistic and effective in their collaboration with "physical planners."

Dr. Albert Rose in his study conveys much of what a social worker needs to know and understand in order to be effective in redevelopment projects relating to slum clearance and public low rental housing erected on the cleared site. Moreover, with scrupulous attention to research limitations and with modest restraint, he details the probable effect of the Regent Park project (for more than 5,000 persons in about 1,200 families), on family welfare, physical and mental health, and juvenile delinquency. Although the experience is Canadian, much of what Dr. Rose explains is equally applicable to the United States—e.g., public attitudes to low rental housing, problem of determining eligibility requirements, the problem of rent determination, the administration of the project, the neces-

sity of citizen understanding and support, the law's delay, the slings and arrows of outrageous opinion from some public groups, and so on. Dr. Rose exhibits in objective and illuminating detail what the problems and issues of social policy were, how these problems and issues were analyzed, and the basis upon which decisions were made. He has done a neighborly deed for us in his account of Regent Park.

The volume by Loring, Sweetser, and Ernst is of particular interest to the field of community organization in social work. The provisions of a workable program for urban renewal call for citizen participation. Physical planners have been hesitant, on the whole (there are a few exceptions—Dayton, Philadelphia, Baltimore), to stimulate and sustain grassroot citizen participation in urban renewal which, in their view, is time-consuming, slow-moving, with apparently trivial results. And yet, redevelopment alone, *i.e.*, major surgery of tearing down and building anew, cannot possibly take care of growing blight in the city core—the more practical approach is massive citizen participation in renewal (*i.e.*, conservation and rehabilitation) of what exists in that core.

The authors cite numerous detailed case studies which demonstrate specific and practical ways and means of securing citizen participation. The cases cited are varied, embracing neighborhood associations, district councils, and citywide citizen advisory groups, with clear delineation of problems encountered on various levels and very helpful guidelines on what approaches will yield probable good or bad results. Moreover, they have boldly sought to generalize from these experiences about community social structure, qualifications of the community organization worker, and the relationship of the worker to renewal planning.

Although they do not subscribe to the proposition that the community organization worker trained in a school of social work is the only one equipped to do the enabling job on a citizen group level, the

authors do document the desirability for such trained workers. In fact, their exposition of the knowledge, understanding, and skill required leans heavily upon the thinking from the field of community organization as conceived by social work.

There is a challenge in this important book to social work: Can our schools of social work step up their training of community organization workers? Can our welfare agencies take hold and participate effectively in urban renewal? Can the social work profession effectively collaborate with other disciplines involved in urban renewal?

The authors have produced a possible index of population potential for participation in urban renewal activities which merits careful study. If such an instrument can be perfected it could be a critical tool in deciding which neighborhoods to select for renewal efforts.

MEYER SCHWARTZ

*University of Pittsburgh
Graduate School of Social Work
Pittsburgh, Pennsylvania*

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Book Reviews

SOCIAL SCIENCE IN THE PROFESSIONAL EDUCATION OF SOCIAL WORKERS. By Grace Longwell Coyle. New York: Council on Social Work Education, 1958. 69 pp. \$1.00.

This lengthy essay treats with the relationship between the social sciences and social work, the attempts to incorporate social science concepts into social work teaching, and the problems thereby generated for professional education.

The essay opens with a discussion of the mistrust and skepticism among social workers regarding the potential contributions to social work of the social sciences, and analyzes the sources of these attitudes. Despite this negativism, the attraction of the social sciences for social work educators is becoming increasingly compelling. The reason for this is that a professional curriculum must, by its nature, be bi-structured, consisting of both clinical and basic content. Thus, medical training, though practice-oriented, gives prominence to such biological sciences as anatomy, microbiology, and physiology. Analogically, social work education cannot reject its reliance upon the social sciences. Nor has it done so. Examining the 1956-57 catalogue offerings of the schools of social work, the author identified all courses with social science content. Subsequent correspondence with the teachers of these courses netted more detailed descriptions of them. This brief reconnaissance has revealed a greater incorporation of social science concepts into social work teaching than is generally appreciated. The essay closes with a discussion of the crucial questions generated by this educational trend, among them that of the proper composition of social work faculties.

In clear and frugal style, the author has thought through a number of perplexing issues and has produced fruitful formulations for them that bear the imprint of her rich background as practitioner and teacher.

ERNEST GREENWOOD

*University of California
School of Social Welfare, Berkeley*

MATE SELECTION. A Study of Complementary Needs. By Robert F. Winch. New York: Harper & Brothers, 1958. 349 pp. \$5.00.

In this very readable book, Winch develops a theory of mate selection which not only is compatible with the behavioral theory applied in social work practice but adds a slightly new conceptual tool for use in studying marital interaction. The author hypothesizes that, in a cultural setting where choice of mate is based principally on emotional attraction, a key determinant of the mutual attraction leading to marriage is the complementariness of the individuals' needs; that is, a relation of their needs such that satisfaction of needs of one partner simultaneously gratifies needs of the other. This relation is likely to be achieved when the needs of the two persons differ markedly in degree or kind, as in the instance of the dominant husband and the submissive wife, not when the needs coincide, as in the case of two dominant or submissive persons.

The observation that reasonably satisfactory marriages may be attained by highly neurotic marital partners because of the interaction of their needs is not new. However, Winch extends this principle to mate selection in general, and tests his theory by detailed analysis of the interrelation of selected needs in a relatively homogeneous group of twenty-five young married couples of the American middle class, a group he believes particularly likely to exemplify the theory of complementariness. His findings give considerable support to the hypothesis, although the statistical evidence is not so strong as implied. The quantitative approach is supplemented by a qualitative analysis of the case material from which are derived several proposed types of marital pattern based on complementary needs. The case examples are convincing in content though few in number.

The author is properly cautious in warning against generalization from a single

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Edited by Georgene Seward, Ph.D.

Foreword by Edward Stainbrook, Ph.D., M.D.

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One Marriage, Two Faiths

Guidance on Interfaith Marriage

James H. S. Bossard and
Eleanor Stoker Boll

Based on the authors' wide experience in research and family counseling, this book clearly and impartially shows how marriage relationships bring to light deep-seated attitudes and habits derived from varying traditions: national, social, economic, and religious. Many illuminating cases are cited. *"Should be read by all . . . marriage counselors, social workers, or others who perform any educational or counseling task in relationship to marriage."*—Luther E. Woodward, New York State Department of Mental Hygiene. 180 pp. \$3.50

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study of a small sample drawn from a circumscribed cultural group. He is somewhat less cautious in attempting to check the applicability of his theory through impressionistic observations of mate selection in several European countries. He manages to explore an amazing range of subject matter in this relatively small book, which opens with a review of ideas of love from Aristophanes to Reik and Fromm. He includes a chapter by Linton C. Freeman on patterns of mate selection in cultures where love is not regarded as a prerequisite to marriage, and points to some of the probable variations from his theory in different social class groups within this country.

Martha Winch, the author's wife and the executive of a family service agency, contributes a chapter on the implications of the theory of complementariness for marital counseling. She points to the utility of the theory in understanding marital interaction, in identifying the cohesive as well as the divisive factors in marriages, and in helping to predict marital conflict. The theory propounded clearly underlines the importance of working with both marital partners and the danger of treatment of one without full awareness of its possible effect on the other.

Social work, after several decades of divorcement, has in the last few years turned again to sociology. It has, for instance, found role theory useful in understanding social functioning. It has reawakened to the importance of socio-cultural differences in determining individual behavior patterns and goals. The theory of complementariness, while deriving more from social psychology than sociology, is presented by a sociologist who offers another conceptual tool of sufficient promise to justify further examination.

ANN W. SHYNE

*Institute of Welfare Research
Community Service Society
New York, N. Y.*

Social Work

DYSFUNCTION ASSUMES PERFECTION

Werner Boehm's "The Nature of Social Work" (April 1958) is probably the best "general" article that I have yet read in your journal. Its articulation of the profession's assumptions, values, goals, functions and activities—and their relationships—is a model of clarity.

Nevertheless, I must challenge one of the fundamental assumptions of the article: the concept of *social dysfunction*. This concept unfortunately is not defined except by sub-categorization ("prevention of problems . . . of interaction" and "prevention of social ills").

Its converse—social functioning—consists of "those activities considered essential for performance of the several roles which each individual . . . is called upon to carry out" and is insufficiently definitive for purposes of this discussion and must largely be discounted. We may impute a rough meaning to this idea of social functioning, however, by mentioning the classic analogy to the biological functioning of a living organism in which all the parts carry out their assigned roles in relationship with one another. This meaning (if not the figure) seems to be supported by Boehm, who recommends "viewing the individual and his environment not as two separate entities but as an interactional field."

But there is a serious flaw in this concept, and especially in its conversion to social dysfunction: it assumes perfection, timeless, and our only task is to find it. There is no place in this theory for a change in the field (or organism or world) itself but only in the relationship of the parts thereof. And change (as in an organism) is orderly and predictable if only we can learn the order and how to predict it. The concept not only makes the world out to be something it isn't; almost worse, it makes it dull. Yet Boehm maintains that ". . . the application in social work of the concept of the interactional field promises for social work a . . . *final achievement* (my italics) of the

long-sought integration between the individual and social approach."

I do not mean to attack all "functional" and "field" theories *per se*; their uses are important certainly, but they are also limited. To speak of social dysfunction is to go beyond them. If, in making this point, I have built a straw man, it is only because Boehm has supplied the straw; and a haystack can be a place of seduction.

Boehm himself has remarked, in a slightly different context, that the interaction between man and his institutions is "ever faulty." Let us live with it and work anyway.

WILLIAM FRIEDLANDER

Chicago, Illinois

Mr. Friedlander is not quite right in saying that the notion of social dysfunctioning is not defined in my article. Its implicit definition is contained in my definition of social functioning which he quotes. Dysfunction, then, is a reduction or impairment of social functioning. I have explicitly defined it as "deficiency in social functioning" on page 16 in a long paragraph which also contains a description of possible causes and types of dysfunctioning. I have also stated that dysfunctioning becomes of interest to the professional social worker only when it is either individually or socially perceived. I believe that the absence of a rigid and precise definition of dysfunctioning is desirable, at least at present, because we have no precise criteria of a social or individual nature which spell out dysfunctioning. Moreover, changing social and cultural patterns lead to changing standards of functioning and dysfunctioning.

Unfortunately, I must disagree with Mr. Friedlander if he wishes to impute the "classical analogy" of biological functioning to social functioning. I presume he means by what he calls the classical analogy the concept of equilibrium which is taken from physiology. Physiology has given up the notion of perfect equilibrium just as science in general has substituted the notion of scientific probability for the notion

of scientific certainty. I believe that reasoning by analogy would be dangerous here and doubt that we can achieve a better scientific understanding of social functioning by assuming it has the same properties as biological functioning. Let us beware of rash reductionism! This is why I have some hesitation to equate the notion of equilibrium with the concept of social functioning.

Certainly my concept of interaction does not support such an analogy. This concept postulates that individual (somatic and psychic) and social factors are interdependent, that change in one of them affects the whole configuration. Hence, this is a dynamic concept. Change in the interactional field can occur as a result of change in any of its component factors. Professional intervention by the social worker constitutes entrance into the interactional field, hence produces changes in that field. Moreover, what else can be the rationale of professional intervention but to seek change?

WERNER W. BOEHM

Director, Curriculum Study

Council on Social Work Education

THROWING OUT THE BABY

Mr. Doverman's letter on the Levy article, "Is Social Group Work Practice Standing Still?" merits further discussion. His suggestion that trained social group workers belong in organizations that offer services to the emotionally disturbed and socially dis-oriented client, and that the frontier for social group work lies in intimate therapeutic relationships, should sound familiar to social caseworkers. In our own striving for recognition and professional status, (it seems to me this is the essence of what Mr. Doverman's letter asks), we, too, tended to equate professional attainment with the intensity of "psychiatric" service offered to the client. We were looking down our noses at such mundane practices as supportive casework. I think we have moved beyond this to the recognition that every aspect of professional service to people is important and that a social worker employed in

Travelers Aid, a child welfare agency, or a family agency needs no lesser amount of skill than one employed in a psychiatric clinic. Similarly, I could ask, does a social group worker employed in a community center or settlement house need less training than one employed in a residential program?

My own experience as a caseworker in a residential facility, working with emotionally disturbed children, has pointed out the value of a group work program that is cognizant of both the physical and emotional needs of growing children, particularly so for the disturbed children, who very often need more help in developing bodily and social skills. Elizabeth G. Meier, in an article in the March 1958 issue of *Child Welfare* entitled "The Needs of Adolescents in Foster Care," points out that for disturbed, adolescent children in foster placement (and I believe this holds true for disturbed children in residential placement) initial focus may need to be in finding ways to help them overcome developmental lacks. Her article further points out that special tutoring, use of tools and materials, group membership, swimming, dancing lessons may seem minor, but they can be very important in helping a child erect constructive defenses against anxiety arising from anger and sense of helplessness.

I would not like to see social group work throw out all but that which lies in intimate therapeutic relationships, for it would be like throwing out the baby with the water.

Vista Del Mar-Child Care REUBEN PANNOR
Los Angeles, California

It is intriguing to contemplate that at the time final preparations were being made for the National Conference on Social Welfare's "Accent on Prevention" a colleague was making print with the idea that practitioners of one of the basic social welfare methods should confine their efforts to "intimate therapeutic relationships" with people already "caught in the grips of terrible, personal breakdown." We refer to Mr. Doverman's letter in the April issue.

Letters

Who could deny that group workers have a responsibility to use their skills with "individuals who are emotionally disturbed and socially disoriented to a marked degree?" Who could quarrel with the need for social group work practice in a treatment or residential setting? But to limit its practice to this kind of service is a myopic approach to the problems of society with which we are concerned. The methods of social group work are equally significant in those community centers where essentially healthy, "normal" persons come for fun and relaxation and for the fulfillment of less obvious needs, without which fulfillment they might at a later date find themselves involuntarily associating with groups in a closed ward, a detention home, or a general hospital. Not only does a group worker have a responsibility to help healthy people stay healthy but, additionally, to become involved in progressively more meaningful experiences in the community.

Furthermore, these agencies when staffed by social group workers can be of inestimable value to persons leaving the protection of a treatment setting and faced with reintegrating into community life.

Teachers, coaches, recreation workers, and social group workers are "the team" in the community center. The group worker has an important job on this team. Frequently he is in the position to give direction to its work in an administrative capacity. He seldom has the help of the psychologist, physician, psychiatrist, caseworker, and so on, that is usually afforded him in a treatment center. It is his knowledge and understanding, his professional value system that will spell the difference in the use of leisure time activities. If the purpose of these agencies were to turn out skilled dancers or basketball players, then there would be no rationale for the presence of the group worker. This, however, is not the case. These are social agencies with social goals.

MARY DOT MONTE
RITA COMARDA

New Orleans, Louisiana

RESEARCH STUDY CRITICIZED

I gasp, I shudder, I turn my head as I read "An Experimental Study of the Observational Process in Casework" by Roger R. Miller (*SOCIAL WORK*, April 1958). In the research design as described appears the following statement: "Since both first- and second-year students were used, the experimental groups were randomly composed, after stratification according to year of training and field work grade. . . . The obtained sample of 54 students represents 87 percent of the potential subjects." I submit this is the most incredible statement in current research.

In a sampling survey such as was attempted, the first task is to decide upon a hypothesis to be tested and state it in researchable terms. Admittedly this is difficult. But the second task is not difficult at all. It is merely to define the universe from which the sample will be chosen. This must have been omitted or the preposterous statement quoted above could not have been made. In the hypothesis as stated: "The adequacy of the observer's conscious psychological comprehension is said to be positively related to the extent to which he uses free-floating attention and the extent to which his attention is directed internally."

Probably this is not stated as well as it could be. It omits, for example, any condition about the observer being a social worker observer, probably required by practicality. If this condition is added, the universe then contains all social workers and all possible clients!

For the purpose of the research only one client was chosen but the researcher "snuck" this in without warning us of its significance. Suppose we agree it was justified to choose one client and that client in a film, which further changes the problem. Then we are left with the remaining individuals in the universe, all social workers. I hope that it now begins to be clear what a true random sample of this universe or even one

of the parts of the universe would entail. Therefore, when the design was such as to include only students of social work at Western Reserve University, a stupefying number of additional factors were introduced. Let me try to mention just a few.

First, if we assume the sample was random with respect to the student body only, the study does establish a difference which "approached significance" between first- and second-year students. This raises a question of whether the first-year students should have been included at all.

What would have been far more interesting, but was omitted, was the consideration of the difference between the second-year students and the panel. Because, of course, both are members of the universe being studied.

This leads to a still more interesting question: Is it possible to conduct research upon a universe of discourse without any reference to measurement outside of that universe of discourse? Since this research only compares some social workers' judgment with others, does it contain any such measure? I think it could be established that this research design collapses entirely on the basis of such a criterion but it will take a more learned brain than mine to prove it. . . . Since in social work we deal with so many uncontrollable factors, we should be doubly cautious with those factors we can control.

The statement that 54 students represent 87 percent of the potential subjects is not only manifestly untrue, it is nowhere established that 54 students contain *any* of the potential subjects, since none of them are social workers by the criteria of having completed a recognized curriculum.

What did the research prove? Well, I don't know whether it really proved anything, but it seemed to indicate the students at Western Reserve learn to have judgments similar to that of a panel considered expert. My question: Were these panel members their teachers?

AUDREY RAWITSCHER, B.S., M.S.W.
Mother of one

Los Angeles, California

RESEARCH EDITOR REPLIES

The problem investigated is of great importance, and scarcely anything has been done on it at a level of complexity and with a theory as sophisticated as we need for casework. As a beginning at systematic study, Dr. Miller's methods and results seem very promising, and the first study was therefore reported. Time—and Miller's further efforts—will tell us whether or not this has been a false lead.

Mrs. Rawitscher's critique is certainly welcome in a field that sometimes accepts "published results" all too uncritically. Nevertheless, to cite limitations without specifying their effects or offering alternatives is merely paralyzing to a search for knowledge.

Thus, an "independent" criterion of "understanding" might have been predictions about the case, but it is debatable whether prediction (or postdiction or con-diction) are: (a) totally independent; (b) valid for *this* problem at hand. We are still puzzled about a satisfactory criterion. Similarly, for the major hypothesis, "a stupefying number of additional factors" was probably *eliminated* by using one school, and the standard technique of random assignment treatments. The "expert judges" were from Cleveland, but are not regularly on our faculty and several happen to be alumnae of other schools.

Whether relationships found would differ elsewhere (*i.e.*, in other schools) is a simple empirical question. However, it is inefficient to test it without an explicit theory of differences to be expected. We do not have one as yet. It would be desirable to have a broader sample of filmed interviews, *also* differing in some systematic way.

Although the wording is not scrupulous, the nature of the sample is clearly indicated in Miller's necessarily compressed report, as are the other bases for identifying reservations to be held in mind regarding the results.

NORMAN POLANSKY, A.B., M.S., Ph.D.
Father of two
Editor, Social Work Research Section

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